TOWARDS GENDER-SENSITIVE THEOLOGICAL RESPONSES TO HIV AND AIDS: A CRITICAL STUDY OF THE HIV AND AIDS POLICY AND PROGRAMMES OF THE NORTHERN DIOCESE OF THE EVANGELICAL LUTHERAN CHURCH IN TANZANIA

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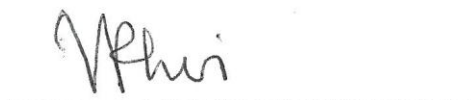**Co-Supervisor: Prof. Sarojini Nadar**

DECLARATION

This dissertation was undertaken at the School of Religion and Theology, University of KwaZulu-Natal, Pietermaritzburg. Unless specified in the text, this thesis is my own work. It has not been submitted in any other university.

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9th March 2011
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As candidate's Supervisors, we hereby agree to the submission of this thesis

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9th March 2011
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Prof. Sarojini Nadar

4th March 2011
Date

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DEDICATION

I dedicate this work to all individuals living with HIV and AIDS and persons already died of HIV and AIDS related illnesses. You are all worthy before God.

ACKNOWLEDGMENTS

Last but not the least; I thank Annalise Zaverdinos for proofreading my work.

ABSTRACT

Beginning with the assumption that HIV and AIDS is a "gendered pandemic," and that the church is central to the lives of many people in Africa, particularly Tanzania, this study sought to assess the HIV and AIDS intervention programmes of the church. The study used the HIV and AIDS programmes and policy of the Northern Diocese of the Evangelical Lutheran Church in Tanzania as a case study, and the central question of this study was: "To what extent have the theological beliefs which under-gird the HIV and AIDS policy and programmes encouraged these programmes to adequately respond to the gender challenges posed by the pandemic?" The hypothesis of this study was that the HIV and AIDS programmes of the ELCT Northern Diocese have not responded adequately to the gender challenges posed by the pandemic among its church members, and that therefore a more gender-sensitive theological response is needed. As such the objectives of this study were:

- To describe and analyze the HIV and AIDS policy and programmes of the ELCT Northern Diocese;
- To investigate whether the HIV and AIDS programmes are gender sensitive;
- To examine to what extent the theological beliefs under-girding the HIV and AIDS programmes and policy encourage gender sensitivity in these programmes;
- To develop theologies that encourage a more gender sensitive response to HIV and AIDS.

The data for the study was collected through in-depth interviews, participant observation, case studies and documentary sources such as primary health education programme annual reports and policy document. From sketching the context of the HIV and AIDS pandemic in Tanzania in general, the study proceeds to describe and analyze the prevailing HIV and AIDS programmes of the ELCT Northern Diocese, which range from HIV and AIDS education awareness, to the provision of medical care, physical and spiritual care. It then assesses the theological beliefs underpinning the diocese's HIV and

AIDS programmes/policy, and examines how the Lutheran Church understands and involves itself in the mission of God, pointing to a way forward in this regard by underlining Luther's practical response to the bubonic plague in relation to HIV and AIDS programmes. Three theoretical frameworks of analysis were used to assist in the analysis of the data collected. These were: a) the gendered conceptual framework for assessing HIV and AIDS interventions as pioneered by Geeta Rao Gupta; b) Luther's theologies of suffering, healing and gender; c) African feminist cultural hermeneutics as pioneered by Musimbi Kanyoro.

The study concludes that as long as the church does not consider the gender nature of HIV and AIDS, its efforts to overcome the pandemic will bear little fruit.

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ABBREVIATIONS AND ACRONYMS

AACC	All Africa Conference of Churches
AALC	All Africa Lutheran Communion/churches
ABC	Abstain, Be Faithful and Condomise
AFNET	Anti Female Genital Mutilation Network
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ART/ARVs	Antiretroviral Therapy/drugs
CCM	Chama cha Mapinduzi (Revolutionary Party)
CCT	Christian Council of Tanzania
CIRCLE	Circle of Concerned African Women Theologians
CEDAW	Convention for the Elimination of Discrimination Against Women
CMS	Christian Mission Society
CRC	Convention on the Rights of the Child
CTC	Care and Treatment Clinic
CBO	Community Based Organization
CPE	Clinical Pastoral Education
DACC	District AIDS Control Coordinator
DHS	Demographic and Health Survey
DIAC	Dodoma Inter-African Committee
ELCT	Evangelical Lutheran Church in Tanzania
ENVIROCARE	Environment, Human Rights Care and Gender Organization
FBO	Faith Based Organization
FGM	Female Genital Mutilation
FHH	Female Headed Households
FLCT	Federation of Lutheran Church in Tanganyika
HBC	Home Based Care
HIV	Human Immunodeficiency Virus

HUYAMWI	Huduma ya Yatima Chuo cha Biblia Mwika (Orphan Ministry at Lutheran Bible School Mwika)
IEC	Information, Education and Communication
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
KCMC	Kilimanjaro Christian Medical Centre
KWIECO	Kilimanjaro Women Information Exchange and Consultancy
KKKT	Kanisa la Kiinjili la Kilutheri Tanzania
KIWAKKUKI	Kikundi cha Wanawake Kilimanjaro Kupambana na UKIMWI (Kilimanjaro Women Vigorously Fighting Against HIV and AIDS)
LBS	Lutheran Bible School
LHRC	Legal and Human Rights Centre
LWF	Lutheran World Federation
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (National Strategy for Growth and Reduction of Poverty)
MOH	Ministry of Health
MTP	Medium Term Plan
MTCT	Mother-to-Child Transmission
MUTAN	Mradi wa UKIMWI Tanzania na Norway (Tanzania and Norway HIV and AIDS Project)
NABA	National Advisory Board on AIDS
NACP	National AIDS Control Programme
NAFGEM	Network Against Female Genital Mutilation
NBS	National Bureau of Statistics
NBTS	National Blood Transfusion Service
NCA	Norwegian Church Aid
NCTP	National Care and Treatment Plan
NGO	Non-Governmental Organization

NMSF	National Multisectoral Strategic Framework
OVC	Orphans and Vulnerable Children
PASUG	Pasua Supportive Group
PEP	Post Exposure Prophylaxis
PEDP	Primary Education Development Plan
PHEP	Public Health Education Programme
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PO-PSM	Public Services Management in the President's Office
RACC	Regional AIDS Control Coordinator
RMO	Regional Medical Officer
SACCOS	Savings and Credit Co-operative Societies
SAP	Structural Adjustment programme
SOSPA	Sexual Offences Special Provisions Act
STDs/STIs	Sexually Transmitted Diseases/Infections
TAC	Technical AIDS Committee
TACAIDS	Tanzania Commission for AIDS
TAMWA	Tanzania Media Women's Association
TAWLA	Tanzania Women Lawyers Association
TGNP	Tanzania Gender Networking Programme
THIS	Tanzania HIV/AIDS Indicator Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
UCB	Uchumi Commercial Bank
UDHR	Universal Declaration of Human Rights
UKIMWI	Upungufu wa Kinga Mwilini (HIV and AIDS)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	The United Nations High Commissioner for Refugees

UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly Special Session
USA	United States of America
VCT	Voluntary Counselling and Testing
VETA	Vocational Education and Training Authority
VVF	Visico Virginal Fistular
WAC	World AIDS Campaign
WCC	World Council of Churches
WHO	World Health Organization
WOWAP	Women Wake Up
WLAC	Women Legal Aid Clinics
YWCA	Young Women's Christian Association

CHAPTER ONE
INTRODUCTION TO THE STUDY

1.1 Background and objectives

This study is located in the Northern Diocese of the Evangelical Lutheran Church in Tanzania (ELCT)[1] which is located on the slopes of Mount Kilimanjaro in the northeast of Tanzania, and covers an area of 2007 square miles.[2] The 2002 National Population and Housing Census indicates that the Kilimanjaro region has a population of 1 381 149.[3] Of this number, 321 565 are members of the ELCT Northern Diocese.[4] This implies that just over 23% of the population are Lutheran, while others belong to other denominations such as the Roman Catholics, Pentecostals and Anglicans, which are found within the study area. Therefore, it is plausible to presume that at least 50%, if not more, of the people living in this region are Christians.

The ELCT Northern Diocese covers five government administrative districts out of the seven districts of this region. The dominant ethnic group of the diocese is the Chagga, and within this ethnic group there are more than five different dialects. Most of the people who live in this area earn their living through small-scale crop and animal farming and micro-business. Population growth and the collapse of the coffee price in the world market, which was the main cash crop of the region, have driven many young people to the new towns of Himo and Bomang'ombe in search of employment opportunities. Furthermore, a significant number of people, professionals and non-professionals, have migrated to big cities and other parts of the country seeking employment. Some are accompanied by their families but the majority leave them behind and visit them during Easter and Christmas holidays or during emergencies such as illness and death. The migration system has been one of the factors giving rise to the high levels of HIV

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[1] Northern Diocese is one of the 20 dioceses of the Evangelical Lutheran Church in Tanzania (ELCT) as shown in Appendix 10. The abbreviation KKKT or KKKT-DK as will frequently appear in the references refers to the Swahili translation for ELCT or ELCT Northern Diocese.

[2] Kathleen Stahl, *History of the Chagga People of Kilimanjaro,* London: SCM Press, 1964, p. 22.

[3] 2002 Population and Housing Census-General Report, "2002 Regional Census Results," <http://www.tanzania.go.tz/census/kilimanjaro.html>Accessed: 16/09/2006.

[4] Kanisa la Kiinjili la Kilutheri Tanzania, *Kalenda 2006*, Moshi: Moshi Lutheran Printing, 2005.

infection in this region as depicted by Tony Barnett and Allan Whiteside: "The sizeable migrant male population often had wives back 'home' on the mountain protecting inherited land by occupation but living unfulfilled 'partial' lives…Migrant husbands in town; semi-deserted wives on the mountain; HIV and AIDS."[5] The following 1991 document from the ELCT Public Health Education Programme of the Northern Diocese sketches the situation of HIV and AIDS at that time.

> The first AIDS cases were diagnosed in our country in 1983. From that time the pandemic has spread rapidly across all regions of the country. The total number of AIDS patients in the hospitals who were registered by the Ministry of Health has been increasing each year from 3 patients in 1983 to 21 000 patients in 1990.[6]

Kilimanjaro Region	Patients	deaths
1984	1	1
1986	28	16
1988	300	135
1990	956	282
Total	1286	434

> The above statistics do not include patients who did not visit the hospital or those who came to the hospital but their records were not given to the regional medical officers. Likewise, persons living with HIV who are not yet sick with AIDS are not included in this figure who number more than 500, 000 within the country. However, even if the spread of HIV would have to stop today, the number of already infected persons will fall sick between now and ten years to come.[7]

HIV and AIDS was first identified in the Kagera region in the north-western part of Tanzania in 1983.[8] This region, which shares a border with Uganda, was affected by the

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[5] Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century: Disease and Globalization*, New York: Palgrave Macmillan, 2002.

[6] The 2009 report indicates that there were 1 400 000 persons who were living with HIV and AIDS, whereas deaths due to HIV and AIDS related illness accounted to 96 000.

[7] Janet Lefroy, "Hali ya UKIMWI Nchini Tanzania na mkoa wa Kilimanjaro," file DK 23 vol.11, p. 1.

[8] Philip Setel, "Local Histories of Sexually Transmitted Diseases and AIDS in Western and Northern Tanzania," in Philip W. Setel, Milton Lewis and Maryinez Lyons (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*, Westport: Greenwood Press, 1999, p. 121, 129. See also Janet Bujra and Carolyn Baylies, "Responses to the AIDS pandemic in Tanzania and Zambia" in Carolyn Baylies and Janet Bujra with the gender and AIDS Group, *AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia,* London: Routledge, 2000, p. 27.

war between Tanzania and Uganda, which took place in 1978. This could also have been a contributing factor to HIV spreading fast in this region and other parts of the country, as in a war situation there is always a mobility of people from one part of the country to the other. In Chaggaland (Kilimanjaro region), which is the area that is being focused on in this study, the first HIV and AIDS case was diagnosed in 1984.[9] It did not take long before many deaths began to occur. Numerous dead bodies were being brought from the cities or places of employment to be buried at their rural homes. The prevalence of war coupled with migrant labour became the root causes for the spread of HIV in Kilimanjaro. Since then the pandemic has grown in huge proportions, heterosexual relationships being the major mode of HIV transmission across the country.[10]

My motivation to carry out this study is based on the challenges of HIV and AIDS I encountered during my service as a parish minister in this diocese from 1995 to 1999. I encountered a high rate of HIV and AIDS related deaths among young adults, both married and unmarried, and of both sexes. The situation created fear, sadness, anxiety and empathy within the community, as we were all affected. Due to this pandemic, parents lost their children, couples lost their loved ones, and some children were left with one parent while others lost both parents. Those who had grandmothers were cared for by them with limited resources, as there are no government grants for such cases. Unfortunately, there were also vulnerable children who were infected, thus grandmothers had the extra burden of caring for and nursing these children.

Furthermore, child headed households were also a consequence of the great number of deaths due to HIV and AIDS. I also noted that the pandemic was putting a heavy burden

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Magdallen Juma, *Coping with HIV/AIDS in Education: Case of Kenya and Tanzania*, London: Commonwealth Secretariat, 2001, p. 2. The United Republic of Tanzania, *National Policy on HIV/AIDS*, Dodoma, (November 2001), p. 7. John Iliffe, *The African AIDS Pandemic: A History,* Oxford: James Currey, 2006, p. 23.

[9] Philip Setel, "AIDS as a Paradox of Manhood and Development in Kilimanjaro, Tanzania," in *Social Science & Medicine,* 13, (1996), p. 1169. See also Setel, "Local Histories of Sexually Transmitted Diseases and AIDS in Western and Northern Tanzania," p. 129. Lefroy, "Hali ya UKIMWI Nchini Tanzania na Mkoa wa Kilimanjaro," p. 1. KIWAKKUKI: *Let's Fight AIDS Together* - Informational Brochure.

[10] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 7. See also TACAIDS, *Guidelines for Management of HIV/AIDS for Frontline Workers,* (October 2003), p. 1. Flora Kessy, Ernest Mallya and Oswald Mashindano, "Tanzania," in Kondwani Chirambo (ed), *The Political Cost of AIDS in Africa: Evidence from six Countries*, Pretoria: Idasa, 2008, p. 219.

on women, as they were caregivers to sick individuals due to HIV and AIDS related illnesses, despite their other duties. Some women were questioning whether they should leave their marriages for fear of being infected by their unfaithful partners. This situation led to many unanswered questions in my mind and among many congregants. We tried to get involved in a small way but the question still remained: how best could the church respond to these challenges as the number of people infected and affected by HIV and AIDS continued to increase? Moreover, given that HIV and AIDS is a gendered pandemic,[11] what is an appropriate response? Philippe Denis argues that the patriarchal social structure that requires women to submit to the sexual advances of men perpetuates the spread of HIV.[12] He further asserts that the biological make-up of women adds to their greater vulnerability to HIV infection compared to their male counterparts. Moreover, in some cultures HIV and AIDS is known as a "women's disease," therefore women are blamed for spreading HIV.[13]

Given the high prevalence of HIV within the ELCT Northern Diocese, and the fact that a gendered response is clearly needed, this study seeks to find out whether the diocese's prevailing HIV and AIDS programmes have responded to these gender challenges that fuel the spread of HIV among its members. My research question therefore is "To what extent have the theological beliefs which under-gird the HIV and AIDS policy and programmes encouraged these programmes to adequately respond to the gender

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[11] Philippe Denis, "Sexuality and AIDS in South Africa," in Journal of Theology for Southern Africa, 115, (March 2003, p. 75. See also Musa Dube, "Grant Me Justice: Towards Gender-Sensitive Multi-sectoral HIV/AIDS Readings of the Bible, in Musa Dube and Musimbi Kanyoro (eds), *Grant Me Justice! HIV/AIDS & Gender Readings of the Bible*, Pietermaritzburg: Cluster Publications, 2004, p. 7, 8, 9, 10. Denise Ackermann, "From Mere Existence to Tenacious Endurance: Stigma, HIV/AIDS and a Feminist Theology of Praxis," in Isabel Phiri and Sarojini Nadar (eds), *African Women, Religion, and Health: Essays in Honor of Mercy Amba Ewudziwa Oduyoye*, Pietermaritzburg: Cluster Publications, 2006, p. 233. Denise Ackermann, "Deep in the Flesh' Women, Bodies and HIV/AIDS: A Feminist Ethical Perspective," in T. M. Hinga et al. (eds), *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*, Pietermaritzburg: Cluster Publications, 2008, p. 109. UNFPA, "Gender Dimensions of the HIV/AIDS Pandemic: Promoting Gender Equality,"<http://www.unfpa.org/gender/aids.htm> Accessed: 30/07/2010, p. 1.
[12] Denis, "Sexuality and AIDS in South Africa," p. 75.
[13] Dube, "Grant Me Justice," p. 11. See also Fulata Moyo, "Gendered Stigma," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy*, Geneva: WCC Publications, 2003, p. 130. Ezra Chitando, *Living with Hope: African Churches and HIV/AIDS*, Vol. 1, Geneva: WCC Publications, 2007, p. 8.

challenges posed by the pandemic?" In response to this, several questions were formulated to clarify the key questions. These were:

- What do the diocese's HIV and AIDS policy and programmes entail?

- Do the programmes show awareness of gender issues that perpetuate the spread of HIV and AIDS?

- What are the theological beliefs that under-girding the HIV and AIDS programmes and policy?

- What theologies can be developed for relevant HIV and AIDS programmes that consider both men and women?

The objectives of this study are thus:

- To describe and analyze the HIV and AIDS policy and programmes of the ELCT Northern Diocese;

- To investigate whether the HIV and AIDS programmes are gender sensitive;

- To examine to what extent the theological beliefs under-girding the HIV and AIDS programmes and policy encourage gender sensitivity in HIV and AIDS programmes.

- To develop theologies that encourage a more gender sensitive response to HIV and AIDS.

The hypothesis of this study is that the HIV and AIDS policy and programmes of the ELCT Northern Diocese have not responded adequately to the gender challenges that are posed by the pandemic among its church members, and therefore a more gender-sensitive theological response is needed.

1.2 Locating the study within the context of HIV and AIDS as a gendered pandemic

African women theologians and other scholars have written extensively on issues concerning HIV and AIDS and its link with gender and the way this affects women

negatively. Culture, religion, patriarchy and stigma are core factors behind gender issues that reinforce the spread of HIV as will be demonstrated by the already existing literature, for example that of the Circle of Concerned African Women Theologians (the Circle). The Circle publications have made a significant contribution to the theological and academic world, and are exposing the way religion and culture has been used to oppress and dehumanize women.

In this regard, a number of studies have emphasised the importance of a gendered theological response to HIV and AIDS. For example, the 2002 Circle of Concerned African Women Theologians' Pan African Conference, resolved to adopt as its area of focus for 5 years the issue of gender and HIV in Africa.[14] Since then, a number of publications that deal with HIV and AIDS and gender in Africa have been produced by the Circle.[15] The Circle has also worked in collaboration with the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) which is an HIV and AIDS programme of the World Council of Churches as will be discussed later.

Isabel Phiri, drawing on the work of Denis contends that HIV and AIDS is a gender issue.[16] She explains that HIV in sub-Saharan Africa is predominantly transmitted through heterosexual relations, with marriage being the major context in which an African woman contracts the virus. Phiri mentions physiological differences, social and

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[14] Isabel Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," in Isabel Phiri, Beverley Haddad and Madipoane Masenya (eds), African Women, HIV/AIDS and Faith Communities, Pietermaritzburg: Cluster Publications, 2003, p. 6. See also Musa Dube, "In the Circle of Life: African Women Theologians' Engagement with HIV and AIDS," in Ezra Chitando and Nontando Hadebe (eds), *Compassionate Circles: African Women Theologians Facing HIV*, Geneva: WCC Publications, 2009, p. 200.

[15] Isabel Phiri, Beverley Haddad and Madipoane Masenya (eds), *African Women, HIV/AIDS and Faith Communities*, Pietermaritzburg: Cluster Publications, 2003. See also Musa Dube and Musimbi Kanyoro (eds), *Grant Me Justice! HIV/AIDS & Gender Readings of the Bible*, Pietermaritzburg: Cluster Publications, 2004. Mercy Oduyoye and Elizabeth Amoah (eds), *People of Faith & the Challenge of HIV/AIDS*, Ibadan: Sefer, 2004. Elizabeth Amoah, Dorcas Akitunde & Dorothy Akoto (eds), *Cultural Practices and HIV/AIDS: African Women's Voice*, Accra: SWL Press, 2005. Isabel Phiri and Sarojini Nadar (eds), *African Women, Religion and Health: Essays in Honor of Mercy Amba Ewudziwa Oduyoye*, Pietermaritzburg: Cluster Publications, 2006. T. M Hinga et al. (eds), *Women, Religion and HIV/AIDS: Responding to Ethical and Theological Challenges*, Pietermaritzburg: Cluster Publications, 2008.

[16] Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 8. See also Philomena Mwaura, "Violation of Human Rights of Kenyan Women with HIV/AIDS through Stigma and Discrimination," in T. M. Hinga et al. (eds), *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*, Pietermaritzburg: Cluster Publications, 2008, p. 127.

cultural practices, and economic and religious factors as the core reasons for women becoming infected with HIV. She argues that studies show that there are more new infections among married women than among men and children, and that the main cause of this is the sexual and economic subordination of women, which is reinforced by the patriarchal socio-cultural system that prevails on the continent. She further contends that the writings of African women theologians have underlined that: "if nothing is done to change the status of married women, the HIV/AIDS pandemic will go on wiping out communities."[17] Besides the hazards of marriage, Phiri maintains that young women are subjected to sexual violence, which can take place at home and at other places within the communities. She further highlights dry sex, female genital mutilation, widow inheritance, polygamy and multiple concurrent sexual partners as cultural practices and norms that contribute to women's risk of HIV infection in Africa.[18] The present study will be examining these cultural issues which are common to many societies in Africa, and looking at interventions employed to address them if any.

Furthermore, Phiri acknowledges that women are the main caregivers of sick people in the family setting,[19] which is part of the gender role assigned to them by society. She observes that women carry out this task with minimal financial support, and with little knowledge on how to protect themselves from HIV infection, a situation which places them at risk of being infected. Phiri further maintains that although women provide care to their sick husbands and relatives until they die, these same women hardly receive any quality care when they themselves fall sick, due to economic crises that are rife across the African continent and due to their low status in society. She adds that young girls withdraw from school to care for their sick parents or relatives, which continues to place them at a disadvantage as they lack education and skills to attain high paid jobs. To earn the family income, girls are forced to engage in child labour, which leads them to sexual abuse, and in some cases they get married at an early age which, once again subjects them to exploitation and HIV infection. Phiri further argues that elderly grandmothers who used to be looked after by their adult children are now being forced to take care of

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[17] Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 10.
[18] Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 10, 11, 12.
[19] Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 15.

their orphaned grand children with minimal resources.[20] The identity of the main caregivers of sick individuals, and how they cope in view of the economic hardship in the country is also the concern of this study.

Musa Dube contends that research has revealed that unequal power relations between women and men promote the spread of HIV.[21] She argues that gender construction exposes both men and women to various levels of oppression but in most cases women are particularly disadvantaged, for example in the areas of leadership, decision-making and the right to own property, hence making them more vulnerable to HIV and AIDS. Dube further maintains that women's gender roles contribute to their susceptibility to HIV infection particularly in the context of care-giving for the infected and affected persons within their families and community at large.[22]

Dube adds that gender inequality is evident in the popular HIV prevention method of "Abstain, Be Faithful/Monogamous to your partner and Condomise (ABC)."[23] One of her arguments with regard to this strategy is that the existence of sexual violence which is prevalent in many communities in Africa prevents women from practicing abstinence. She further argues that rape not only occurs among women adults but also among young girls and girl-infants, a situation that has been the cause of increasing HIV infection among the rape survivors. Unfaithfulness among marital partners is another limitation of the ABC HIV prevention approach. Dube indicates that studies have shown that 80 percent of HIV positive women were infected by their marital partners.[24] She adds that even when women are aware of the risk - their inferior status in society does not accord them the power to insist on fidelity or safer sex for fear of being abandoned. Furthermore, Dube asserts that culture and religious beliefs continue to play a significant role in confining some women within risky marriages even if they are economically independent which most are not. Another HIV prevention strategy that does not work in the context of

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[20] Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 15.
[21] Dube, "Grant Me Justice" p. 7, 8.
[22] Dube, "Grant Me Justice" p. 8.
[23] Dube, "Grant Me Justice" p. 8.
[24] Dube, "Grant Me Justice" p. 9.

gender disparity is condom use. Dube maintains that the condom has been proved as an effective device to prevent further transmission of HIV if used accurately and with consistency, but since women have no say in sexual matters this has not been an appropriate preventive measure.

Moreover, Dube contends that the HIV and AIDS stigma is also associated with gender.[25] She maintains that the Bible and many African cultures relate women's bodies with disease and uncleanness, including the HIV and AIDS pandemic, so that women in some cultures are blamed for spreading HIV or infecting their spouses. Dube adds that the reproductive role of women facilitates their early HIV testing and treatment as opposed to their male counterparts. However, breaking the news of their HIV positive status to their partners causes some women to be evicted from their marital homes. Addressing the gender dimensions of HIV and AIDS, Dube therefore suggests the employment of a gender-sensitive multi-sectoral approach due to the fact that gender and the HIV and AIDS pandemic are interlinked with one another as well as social, cultural, economic and political aspects.[26]

Elesinah Chauke describes the plight of women in the south east Zimbabwean context with regard to marriage and its link to increased vulnerability to HIV infection.[27] Chauke presents five case studies of women who contracted HIV infection because of their powerlessness within marriage which is fuelled by culture. Since these stories are the reality of many African women, I will describe each of them briefly to set the scene. The first case study focussed on Sylvia, who was forced to marry her brother-in-law after the death of her sister who died of HIV and AIDS related illnesses. Although Sylvia was not ready for this marriage, she had to obey the influence of her family who said to her that "her sister's children were her children and that it was her responsibility to go and take

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[25] Dube, "Grant Me Justice," p. 11.
[26] Dube, "Grant Me Justice," p. 13.
[27] Elesinah Chauke, "Theological Challenges and Ecclesiological Responses to Women Experiencing HIV/AIDS: A South Eastern Zimbabwe Context," in Isabel Phiri, Beverley Haddad and Madipoane Masenya (eds), *African Women, HIV/AIDS and Faith Communities*, Pietermaritzburg: Cluster Publications, 2003, p. 129.

care of them."[28] Within a year of her marriage, Sylvia became pregnant and soon after the birth of her child her husband died. Worse still, Sylvia was also unwell and her child survived for only four months. Surprisingly, the church visited this family only during the funeral service of Sylvia's child despite the fact that the family were church members. However, the emphasis of the sermon of that day was to condemn sinners rather than comforting and encouraging the family with regard to all that they were going through.

The second case study is similar to the one described above and it involves Janet and Susan who were cousins and married to two brothers.[29] Janet's husband fell sick and died of HIV and AIDS related illnesses. The African culture of wife inheritance played a role in this family. The family decided that Janet and her children would be cared for by Susan's husband who was the brother of the deceased. Susan resisted the sharing of her husband and opted to go to her parents. They however refuted her decision and insisted that she had to remain with her husband. Additional pressure came from her husband's family who would demand her family to return the bride price that was paid for her should she decide to leave. All these external forces obliged Susan to stay with her husband. Not long, thereafter Janet also got sick and died. After a few years Susan and her husband died too, hence leaving all their children orphaned. Susan's mother's lamentation was: "Why should culture be taken to be more important than the lives of people?"[30] Although both Janet and Susan were not happy about the decision made for them that they must share a husband, the value of marriage and the pressure which was put on them by culture overruled their choice and eventually terminated their lives.

The common practice of unfaithfulness by marital sexual partners is illuminated by the two subsequent case studies, again which revealed the vulnerability of married women to HIV infection. Rachel is the main character in the first case study. Her husband died of HIV and AIDS related illnesses but the deceased's family put the blame on Rachel. Rachel's husband's family believed that their son was bewitched because Rachel used to

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[28] Chauke, "Theological Challenges and Ecclesiological Responses," p. 129.
[29] Chauke, "Theological Challenges and Ecclesiological Responses," p. 131.
[30] Chauke, "Theological Challenges and Ecclesiological Responses," p. 132.

fight with other women who had affairs with her husband.[31] Rachel knew about the risky sexual behaviour of her husband which caused her to contract the virus, a situation which angered and made her bitter toward the deceased, his family and God too. Nevertheless, Rachel's reaction against her husband's risky behaviour was ignored since unfaithfulness among men is culturally expected and acceptable in many societies in Africa. Rachel was therefore blamed for the death of her husband, even though he was responsible for his own death.

Similar to Rachel, Jesca was infected with the virus by her unfaithful husband who sent her to the village to stay with her parents after the birth of their second child.[32] Although Jesca opposed her husband's decision both families intervened and insisted that she had to obey him. Jesca's husband continued to indulge in sexual activity with other women. After some time, her husband fell sick and returned home to be cared for and nursed by his wife. Before long, he died, leaving behind Jesca with two small children. Jesca like Rachel and many other disadvantaged African women became a widow at an early age, with no source of income and no family moral support.

The final case study reveals the consequence of polygamy in the context of HIV and AIDS. Rose was married as a second wife to Jefta. A few years after her marriage, Jefta's first wife got sick and died due to HIV and AIDS related illnesses. Rose was horrified to the extent that she returned to her family. However, her father and brothers sent her back to her husband, on the grounds that leaving her husband was culturally regarded as a disgrace to her family. A few years later, Jefta also fell sick and died and Rose followed after a few months.

In all five case studies, the preservation of culture was central in that the risky behaviour that endangered women's lives was not taken into consideration as far as male sexuality was concerned. Since wife inheritance, multiple sexual partners and polygamy are common cultural practices and norms in many communities in Africa, one of my

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[31] Chauke, "Theological Challenges and Ecclesiological Responses," p. 132.
[32] Chauke, "Theological Challenges and Ecclesiological Responses," p. 133.

questions in this study is: to what extent have the HIV and AIDS programmes of the ELCT Northern Diocese taken cognisance of these issues?

Chauke observes that the church has barely become involved in alleviating the pain and suffering of its church members. She therefore suggests possible ways of bringing healing to the hurting individuals that include the art of listening to their stories or experiences and delivering a message of reconciliation.[33] She also urges women to resist harmful cultural practices and norms that oppress and dehumanize them at the expense of men.

Ruth Muthei James underlines that poverty and rape are some of the socio-cultural and economic factors that reinforce the vulnerability of a girl-child to HIV infection in Kenya,[34] similar to other communities in Africa. She argues that a girl-child is discriminated against from the day of her birth to the end of her life cycle because of the gender construction that does not consider women as fully human. A sufficient diet, health care and education are some of the crucial rights that a girl child is deprived of by her family and society at large, hence impacting negatively on her, from childhood to adulthood. She maintains that the socialization of girls has to a great extent perpetuated their vulnerability to unwanted sexual activity because they are socialized to be meek and obedient to males under all circumstances.

James further points out that the sickness and high death rate of parents due to HIV and AIDS related illnesses has led many households into a situation of economic crisis.[35] Consequently, many orphaned children, especially girls are withdrawn from school to care for sick parents or relatives. Worse still, these girls have to work to earn a living for the family despite their tender age. Acting as breadwinners, many girls have been trapped into engaging in sex work. She therefore claims that: "These child sex workers are often disadvantaged because they do not have the capacity to negotiate for safe-sex, thereby

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[33] Chauke, "Theological Challenges and Ecclesiological Responses," p. 142.
[34] Ruth Muthei James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," in T. M. Hinga et al. (eds), *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and* Theological *Challenges*, Pietermaritzburg: Cluster Publications, 2008, p. 4.
[35] James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," p. 7.

becoming more vulnerable to transmitted infections including HIV/AIDS."[36] Furthermore, some girl-sex workers affirm that in some cases they are beaten by their clients who also refuse to pay them, and that no condoms are used to protect them from HIV infection.[37]

James notes that many families affected by HIV and AIDS in Kenya send their girl-children to work as domestic workers as a survival coping mechanism.[38] She maintains that the majority of girls in those homes have been subjected to physical and sexual abuse inflicted on them by male family members or friends. Besides the psychological trauma which is the reality of such violence, early pregnancy and the risk of contracting HIV are evident. For instance, research conducted by UNICEF found that:

> of twenty-five girl-children aged nine to eighteen, eighteen were HIV+. Of these, most had worked in several homes and reported having been sexually abused. Fifteen said that their first sexual experiences had been as the result of coercion by their male employer or someone in his family or close circle of friends.[39]

James further explains that the myth that having sexual intercourse with a virgin can cure an HIV positive man is also prevalent in Kenya.[40] She narrates an incident of a crippled and orphaned young girl who conceived after been raped by an HIV positive man who believed that by so doing he would cleanse himself from the virus. This was extremely painful because the rape was initiated by her uncle who received money for it. James argues that girls are at risk of being raped wherever they are, even at the hands of the people who are supposed to safeguard them. She adds that more than 70 percent of girls and women who are raped in Kenya know their rapists and that in most cases no action is taken in response to the crime partly because issues of sexuality are "often surrounded by a conspiracy of silence."[41] James highlights that studies reveal that girls are raped as early as one year old. The present study will investigate whether the diocese's HIV and AIDS

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[36] James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," p. 9.
[37] James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," p. 10.
[38] James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," p. 12
[39] James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," p. 12.
[40] James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," p. 14.
[41] James, "Factors that Render the Girl-Child Vulnerable to HIV/AIDS in Kenya," p. 13.

programmes address the economic status of women and girl children as well as the sexual abuse which is rampant in contemporary Tanzania. If the diocese is not addressing these issues, what is the theological motive which hinders this?

 Another important study by Ruth Oke examines the practice of early marriage which is very common in the northern part of Nigeria.[42] In the Nigerian context, a child is legally considered to be a person whose age ranges from 0 to 17, and who is in need of guidance and protection from her parents in all circumstances. Despite this awareness, parents marry off their daughters at the age of ten to fifteen to older men. Commenting on the wide age gap, Oke says: "One of the partners is not qualified to fulfil the marital obligations because there is no mutual relationship in this type of marriage."[43] She adds that at this age, girl children are at their developmental stage in that some of them have barely even started their menses, and are hence unable to cope with marital life and the responsibilities associated with it.

Oke mentions some of the reasons that contribute to child marriage in Nigeria. These include a suspicion of formal education which is believed to corrupt girls, fear that girls will indulge in pre-marital sex which will bring shame to their parents, the greed of girls' parents in wanting to earn income from the groom's family in form of bride price, and also the abject poverty which is the reality of many households.[44] Marrying off their girls is then regarded as a form of relief for households with limited resources, because of the negative attitude towards girls' education. On the contrary, the boy child is considered as the "family investment." Verifying arguments with regard to early marriage in Nigeria, Ejemb cited in Oke conducted a study whose findings revealed that there was a high rate of girls who were married at the age of 12, 13, 14 and 15 which amounted to 17.5%, 42.8%, 42.7%, and13.7% respectively out of a sample of 314 girls.[45]

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[42] Ruth Oke, "Child Marriage: "A Ticket to HIV/AIDS," in Elizabeth Amoah, Dorcas Akitunde and Dorothy Akoto (eds), *Cultural Practices: African Women's Voice*, Accra: SWL Press, 2005, p. 37.
[43] Oke, "Child Marriage," p. 37.
[44] Oke, "Child Marriage," p. 38.
[45] Oke, "Child Marriage," p. 39.

Oke underlines critical social and health problems linked to underage marriage as being: loss of empowerment, ignorance about marital life, the increase of infant mortality due to the illiteracy of the mother as well as maternal mortality associated with pregnancy complications.[46] The risk of Vesico Virginal Fistular (VVF) which refers to the inability of a girl to control the flow of urine after delivery, and the vulnerability to contracting HIV are also equally detrimental to a girl child's health.[47] She comments that the struggle of women activists with regard to the rights of girls by pressurizing the Nigerian government to state clearly the acceptable age for marriage, has thus far been unsuccessful.[48] This is due to the fact that the practice of child marriage is still common particularly in the northern part of Nigeria, and attempts to end it would be highly unpopular.

The present study will examine whether the HIV and AIDS programmes of the diocese are creating awareness about the effects of early marriage which is occurring despite the fact that the bylaws do not allow the church to officiate a marriage for partners who are underage. Although the church may abide by this law, other religions cherish early marriage as part of their faith. The question which this study raises is: how sensitive is the church to early marriage issues and problems in terms of its response to other religions, and in view of the practice of illegal underage marriages which are then blessed when the couple have reached the legal age?

Mae Alice Reggy-Mamo[49] writes from her own experience as a widow in the Luo ethnic group. She observes that:

> The death of a husband has a powerful impact on the widow; her sense of personal identity becomes disoriented. Women tend to suffer more than men do from the loss of status after the death of their spouse because a married woman achieves status in society through her

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[46] Oke, "Child Marriage," p. 40, 41.
[47] Oke, "Child Marriage," p. 41.
[48] Oke, "Child Marriage," p. 42.
[49] Mae Alice Reggy-Mamo is an African-American widow who was married to a Kenyan Luo and later re-married to a widower from Ethiopia.

husband…A widow experiences not only the loss of her husband, but also the sudden devalued status of not being married.[50]

Reggy-Mamo highlights that the loss of financial support, property and health are some of the crucial issues many widows encounter. She maintains that some widows in Kenya are financially handicapped, and after the death of their husbands are often left with debts because the deceased relatives confiscate the property of the dead man. She adds that the situation of a widow is worse if she does not have a married son since this prevents her from owning any property from her marriage.[51]

While Luo society has a well defined social support system that is in fact meant to cater for the needs of the widow and her children, Reggy-Mamo contends that there are also oppressive cultural practices that dehumanize and subject widowed women to health risks especially in the context of HIV and AIDS. Levirate union and widow cleansing remain prevalent practices among the Luo[52] as is the case in many other communities in Africa. Reggy-Mamo however notes that some Luo families do not insist that the widow must be inherited by the male relatives of the deceased husband, while other widows who for various reasons did not undergo the ritual of cleansing while alive, are cleansed after their death, when the family hires a mentally sick man to have sexual intercourse with the corpse before it is buried.[53]

In addressing the crisis of widows, Reggy-Mamo urges the church to sponsor them in order to facilitate the creation of income generating projects that will enable them to be self-supporting, hence avoiding dependence on the male relatives. She also reminds the church to be vocal on the oppressive cultural practices that dehumanize and impoverish widows such as widow cleansing and property grabbing. The current study will examine the situation of widows in Tanzania and how the government, through its laws, protects the rights of widows with regard to property and dehumanizing cultural practices. It will

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[50] Mae Alice Reggy-Mamo, "Levirate Custom and HIV/AIDS: A Personal Experience," in Elizabeth Amoah, Dorcas Akitunde & Dorothy Akoto (eds), *Cultural Practices and HIV/AIDS: Women's Voice,* Accra: SWL Press, 2005, p. 45.
[51] Reggy-Mamo, "Levirate Custom and HIV/AIDS," p. 45.
[52] Reggy-Mamo, *"Levirate Custom and HIV/AIDS,"* p. 47.
[53] Reggy-Mamo, "Levirate Custom and HIV/AIDS," p. 57.

also look at the church's response to the socio-cultural, economic and spiritual needs of the widows. The next section will examine the joint efforts of EHAIA and the Circle in addressing the pandemic.

The Ecumenical HIV and AIDS Initiative in Africa (EHAIA) which is a World Council of Churches programme, works in collaboration with the Circle of Concerned African Women Theologians (the Circle) in addressing the HIV and AIDS pandemic. EHAIA was formed in 2002 as a response to the Plan of Action which was drawn up during the World Council of Churches' Global Consultation on Ecumenical Responses to the Challenges of HIV and AIDS in Africa, which took place in Nairobi in 2001.[54] The Plan of Action was established to guide churches to urgently address the pandemic in the areas of theology and ethics, education, training, prevention, care and counselling, advocacy, support, gender, culture and liturgy.[55] EHAIA therefore demonstrates that the HIV and AIDS competent church is achieved through five main objectives:

- The teaching and practice of the churches indicate clearly that stigma and discrimination against PLWHA is a sin and against the will of God.
- Churches and ecumenical partners have a full understanding of the severity of the HIV/AIDS pandemic in Africa.
- Churches in Africa reach out and respond to collaborative efforts in the field of HIV/AIDS.
- Churches find their role in the prevention of HIV/AIDS, taking into consideration pastoral, cultural and gender issues.
- Churches use their resources and structures to provide care, counselling and support for those affected.[56]

Besides, the programme executive who is based in Geneva, EHAIA activities are run by four regional coordinators, in West, East, Central and Southern Africa, and the organisation currently has two theology consultants (one for the Francophone regions and

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[54] The Ecumenical HIV/AIDS Initiative in Africa (EHAIA), <http://www.ecupace.net/contact.nsf/5e7350302ae366658c1256d0c004edeb3/AAA186...>Accessed: 06/07/2010, p. 1.
[55]WCC, *Plan of Action: The Ecumenical Response to HIV/AIDS in Africa*, Nairobi, Kenya 25-28 November 2001. See also Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 7.
[56] The Ecumenical HIV/AIDS Initiative in Africa, p. 1.

the other for the Anglophone regions).[57], Musa Dube, one of the active Circle members from Botswana, was the first EHAIA theology consultant who was hired by the WCC to train theological educators to mainstream HIV and AIDS in their "teaching, research and service to faith - based organisations,"[58] a position she held for three years.[59] Prior to this post, Dube was employed as EHAIA regional coordinator for Southern Africa.[60] In the course of carrying out this enormous task, Dube acknowledges that she worked with numerous Circle members and male theologians to train over 740 African educators of theology and religion to mainstream HIV and AIDS in their courses in sub-Saharan Africa.[61] She also notes that Circle members played a significant role in organising workshops and in some cases they were resource persons. This is one area in which Circle and EHAIA have been working in collaboration in the context of HIV and AIDS.

The production of appropriate resource materials to facilitate the mainstreaming of HIV and AIDS in theological institutions is the second area which has been jointly tackled by EHAIA and the Circle.[62]

Dube notes that many of the articles, sermons and liturgies that constituted the first two volumes were written by African women theologians (Circle members).[63] Similarly, the articles in the latter volume were all written by Circle women, except one. In addition, Circle women were involved in formulating an HIV and AIDS curriculum for the Theological Education by Extension (TEE) body in Africa which entailed ten modules.[64]

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[57] EHAIA Newsletter, "EHAIA Occasional Newsletter – December 2008," <http://www.oikumene.org/programmes/justice-diakonia-and-responsibility-for-creation...> Accessed; 06/07/2010, p. 17.
[58] Dube, "In the Circle of Life," p. 207, 208. See also Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 7.
[59] Dube, "In the Circle of Life," p. 208.
[60] Dube, "In the Circle of Life," p. 208.
[61] Dube, "In the Circle of Life," p. 208.
[62] Dube, "In the Circle of Life," p. 207, 208, 209, 210. See also Nontando Hadebe, "Introduction," in Ezra Chitando and Nontando Hadebe (eds), *Compassionate Circles: African Women Theologians Facing HIV*, Geneva: World Council of Churches, 2009, p. 10. Three publications of note are Musa Dube (ed), *HIV and AIDS and the Curriculum: Methods of Mainstreaming HIV/AIDS in Theological Programmes*, Geneva: WCC Publications, 2004. Musa Dube (ed), *Africa Praying: A Handbook of HIV/AIDS Sensitive Sermon and Liturgy*, Geneva: WCC Publications, 2004, and Ezra Chitando and Nontando Hadebe (eds), *Compassionate Circles: African Women Theologians Facing HIV*, Geneva: WCC Publications, 2009.
[63] Dube, "In the Circle of Life," p. 210.
[64] Dube, "In the Circle of Life," p. 210.

With regard to gender issues, Phiri states that the idea to develop a gender-sensitive course was initiated by the Circle in September 2003.[65] This work is still in progress and the handbook to be published is titled *Engendering Theological Education*.[66] Dube is clear about the importance of gender training in the theological programmes in this era of HIV and AIDS when she says: "The aim of the handbook is to assist and to challenge African theological educators to mainstream gender in their programmes."[67]

Given that EHAIA is mandated to help churches to engage fully in the prevention of HIV and AIDS, by taking into consideration cultural and gender issues among others, this organisation has started working with churches and other partners across the continent to "bring about greater societal acceptance of transformative or redemptive masculinities in the fight against HIV and AIDS."[68] Challenging traditional gender roles and power relations within the church which have undermined women, hence contributing to the transmission of HIV, are part of the package of the EHAIA initiative. Addressing sexual abuse against women and children in all spheres is also the focus of EHAIA.

EHAIA is therefore organizing workshops that target men and boys as a process of journeying and preparing them to move from dangerous masculinities to responsible or redemptive masculinities, especially in the context of HIV and AIDS.[69] In 2008, for example, EHAIA conducted three workshops on masculinities in Kenya, Lesotho and Malawi.

Presenting his insight on engaging men in the fight against gender based violence, Ezra Chitando, (EHAIA theology consultant in the Anglophone regions) contends that the concept of "masculinities" in plural form is becoming widely accepted because people are aware that men are not all the same.[70] He further argues that development workers comprehend that even if they belong to the same community, men's beliefs and value

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[65] Isabel Phiri, "The Circle of Concerned African Women Theologians: Its Contribution to Ecumenical Formation," in *The Ecumenical Review*, 57, 1, (January 2005), p. 38.
[66] Dube, "In the Circle of Life," p. 211.
[67] Dube, "In the Circle of Life," p. 211.
[68] EHAIA Newsletter, "EHAIA Occasional Newsletter," p. 4.
[69] EHAIA Newsletter, "EHAIA Occasional Newsletter," p. 4.
[70] EHAIA Newsletter, "EHAIA Occasional Newsletter," p. 6.

systems within that community are diverse. It is from this basis that EHAIA is committed to work with men to "[encourage] progressive values and discourage dangerous beliefs and practices."[71] With regard to gender based violence, Chitando maintains that there is a possibility of working with men to promote new values that uphold more gender equitable/friendly norms and behaviours, and hence also to eliminate gender based violence.

In conclusion, this section explored the vulnerability of women and girl children to HIV infection, which is reinforced by socio-cultural, economic and religious aspects. Unequal power relations between men and women, sexual violence, multiple sexual partners, wife inheritance, polygamy, early marriage, widow cleansing and property grabbing are the experiences of women in sub-Saharan Africa, even in the dangerous context of HIV and AIDS because of patriarchal systems which pervade all spheres of society. Hence, it is clear that HIV and AIDS cannot be addressed without considering the context of gender inequality in which HIV and AIDS thrives. It was noted that the church has not been prophetic enough in addressing these practices which rob women of their dignity and lives. However, EHAIA has recently begun to work with churches to enable them become competent in responding to all the multifaceted aspects of the pandemic, especially the gender related issues. Workshops that target the male gender at each age-level are among the strategies employed by EHAIA. These workshops provide a space to involve, to empower and to change men's attitudes and behaviours that fuel the spread of HIV. This work will assess the extent to which the ELCT Northern Diocese's HIV and AIDS programmes are responding to the abovementioned gendered issues which threaten women's lives.

1.3 Structure of the study

The current chapter presents the background and the motivation of the study. The research problem, objectives, hypothesis, literature review and structure of the study are discussed.

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[71] EHAIA Newsletter, "EHAIA Occasional Newsletter," p. 7.

Chapter 2 presents the theoretical frameworks of the study. These were three, namely: a gendered conceptual framework for assessing HIV and AIDS interventions, Luther's theology of suffering, healing and gender and African feminist cultural hermeneutics.

Chapter 3 underlines the methods and methodology which were used in the research. Individual in-depth interviews and documentary sources were the main sources of information.

Chapter 4 sketches the context of the HIV and AIDS pandemic in Tanzania, the modes of its transmission and the determinant factors in this. The chapter also presents the national response to the HIV and AIDS pandemic.

Chapter 5 describes the prevailing HIV and AIDS programmes of the ELCT Northern Diocese, which range from AIDS education awareness, to the provision of medical care, physical and spiritual care.

Chapter 6 describes the theological beliefs underpinning the diocese's HIV and AIDS programmes/policy. It further examines how the Lutheran Church understands and involves itself in the mission of God. The chapter also underlines Luther's practical response to the bubonic plague in relation to HIV and AIDS programmes. Lastly, it identifies the shortcomings and strengths of his theology.

Chapter 7 proposes theologies that take into consideration the issue of gender justice.

CHAPTER TWO
THEORETICAL FRAMEWORKS

2.1 Introduction

In the first chapter I explored the background and motivation for my study and showed how this research builds on and expands the work already done in the area of gender and HIV and AIDS. I also argued that it is important to assess the extent to which the church is offering a gendered response to the pandemic, given that HIV and AIDS is a gendered pandemic. In this chapter I show what theoretical frameworks are important for such an analysis.

The analysis of the work was guided by three theoretical frameworks, namely: the gendered conceptual framework for assessing HIV and AIDS interventions as proposed by Geeta Rao Gupta,[72] a Lutheran theology of suffering, healing and gender based on Martin Luther's teachings,[73] and African feminist cultural hermeneutics as pioneered by Musimbi Kanyoro.[74] Each of these frames of reference was used to analyze the fieldwork, case studies and documentary information.

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[72] Geeta Rao Gupta, "Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How," <http://www.crw.org/docs/Durban_HIV/AIDS_speech700.pdf >Accessed: 21/07/2006. See also UNAIDS, "Facing the Future Together: Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa," <http://womenanaids.unaids.org/regional/docs/Reprt%20%20SG's%20Task%20Force.pdf> Accessed: 11/11/2009, p. 7, 47.

[73] Walther von Loewenich, *Luther's Theology of the Cross*, Belfast: Christian Journals Limited, 1976. See also Paul Althaus, *The Theology of Martin Luther*, Philadelphia: Fortress Press, 1966. Ronald F. Thiemann, "Luther's Theology of the Cross-Resource for a Theology of Religion," in Christine Helmer (ed), *The Global Luther – A Theologian for Modern Times*, Minneapolis: Fortress Press, 2009. Isaiah Mojok Dau, *Suffering and God: A Theological reflection on the War in Sudan*, Nairobi: Paulines Publications Africa, 2002. Martin Luther, *Luther: Letters of Spiritual Counsel,* London: SCM Press, 1955. Martin Luther, "Whether one may flee from a deadly plague," in Gustav Wiencke (ed), *Luther's Works,* Vol. 43, Philadelphia: Fortress Press, 1968. Susan Karant and Merry Wiesner, *Luther on Women: A Sourcebook*, New York: Cambridge University Press, 2003. See also Merry Wiesner, "Luther and Women: the Death of Two Marys in Ann Loades (ed), *Feminist Theology: a reader,* London: SPCK, 1990.

[74] Musimbi Kanyoro, *Introducing Feminist Cultural Hermeneutics: An African Perspective*, New York: Sheffield Academic Press, 2002.

2.2 Gendered conceptual framework – Rao Gupta

Firstly, the gendered conceptual framework of Gupta consists of five ways of assessing HIV and AIDS programmes.[75] These are: a) programmes that focus on stereotypes of women and men; b) programmes that are gender neutral; c) programmes that are gender sensitive; d) programmes that aim at empowerment; and e) programmes that are transformational. This framework is crucial for my study especially in so far as I will analyze the extent to which the HIV and AIDS programmes of the ELCT Northern Diocese are gender sensitive.

2.2.1 Programmes that focus on stereotypes of women and men

The stereotype based programmes regard men as dominant in sexual matters, whereas women are seen as weak and unable to protect themselves.[76] Sex workers are portrayed as vectors of HIV transmission. Such educational messages mislead the populace because it is only women who are regarded as prostitutes, while their male clients are not. This attitude facilitates the spread of HIV since men continue to have sexual relations with numerous partners, including their marital partners. In addition, these programmes also categorize certain groups of people as sources of HIV infection, such as long distance truck drivers, sex workers, black people, drug users, refugees and homosexuals.[77] This categorization is potentially dangerous because it gives false hope to people who do not fall within these categories. The reality is that anyone who is sexually active is at high risk of being infected with HIV. The high rate of HIV infections and deaths among young people and adults of reproductive age in Tanzania clearly indicate this. For instance, the country estimates indicate that 1 400 000 people were living with HIV and AIDS by the end of 2009 and the annual death rate was 96 000.[78] This scenario confirms that HIV

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[75] Rao Gupta, "Gender, Sexuality, and HIV/AIDS," p. 4, 5, 6.

[76] Rao Gupta, "Gender, Sexuality, and HIV/AIDS," p. 4.

[77] UNAIDS, "Facing the Future Together," p. 47. Dube, "Grant Me Justice" p. 6. See also Arvind Singhal and Everett Rogers, *Combating AIDS: Communication strategies in action,* New Delhi: Sage Publications, 2003, p. 250. Douglas Webb, *HIV and AIDS in Africa*, London: Pluto Press, 1997, p. 27. Ruth Muthei James, "The Promotion of the 'ABC' in the Prevention of HIV/AIDS in Africa: Implications for Women," in Mercy Oduyoye and Elizabeth Amoah (eds), *People of Faith and the Challenge of HIV/AIDS*, Ibadan: Seifer, 2004, p. 163.

[78] UNAIDS, "United Republic of Tanzania," <http://www.unaids.org/en/CountryResponses/Countries/united_republic_of_tanzania.a...>Accessed: 20/7/2010, p. 1.

infection is spreading across the population, regardless of gender, age, social status and profession. At the outset of the pandemic, the national HIV and AIDS report indicates that youth, women, poor and the mobile population were the categories of people who were mostly affected by the pandemic. On the one hand this is the reality, but on the other hand all sexually active people can contract the virus as mentioned above. This particular aspect is an important one to bear in mind when analysing the programmes of the ELCT Northern Diocese. To what extent do these programmes rely on stereotypes of women and men? What are the theological beliefs regarding women's and men's roles and places in church and society?

2.2.2 Programmes that are gender neutral

Gender neutral programmes, as asserted by Rao Gupta address both men and women equally without taking into account that each gender is affected differently.[79] An example of this approach is the worldwide prevention message of Abstain, Be faithful (monogamous) and Condomise (ABC).[80] Theoretically, abstinence is the best method to prevent HIV, but the prevalence of sexual violence against young and adult women in many societies in Africa, as discussed above, has made women unable to adhere to such a strategy. Rape incidences have increased in Tanzania in recent times, a situation which may subject an individual to HIV infection.[81] In other parts of Africa, men who are aware of their HIV-positive status, rape young girls or infants in the belief that they can cure

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[79] Rao Gupta, "Gender, Sexuality, and HIV/AIDS," p. 5. See also UNAIDS, "Facing the Future Together," p. 7.

[80] Shereen Usdin, *The No-Nonsense guide to HIV/AIDS*, London: New Internationalist, 2003, p. 127, 128. See also Dube, "Grant Me Justice," p. 9. Musa Dube, "Adinkra! Four Hearts Joined Together: On Becoming Healing-Teachers of African Indigenous Religion/s in HIV & AIDS Prevention," in Isabel Phiri and Sarojini Nadar (eds), *African Women, Religion, and Health: Essays in Honor of Mercy Amba Ewudziwa Oduyoye*, Pietermaritzburg: Cluster Publications, 2006, p. 136.

[81] One of the incidents was reported by Radio One on 09/08/2008 under the headline, "Waziri wa Maendeleo ya Jamii, Jinsia na Watoto angua kilio," (The Prime Minister of Social Development, Gender and Children burst into tears). This report states that the Minister Honourable Margreth Sitta together with the representative of the cabinet committee of Social Development the Honourable Al-Shymaa Kwergy visited a school girl, Maria Halimoja in DodomaRegional Hospital where she was admitted after been raped, and stabbed by a hot knife by her relatives as punishment because she disclosed the matter to her teachers. The report goes further to say that the two authorities burst into tears as the girl was narrating the incident to them. Halimoja told the minister that the perpetrator of the rape has already died. Her teachers who were taking turns to nurse her at the hospital explained to the minister their efforts to get their student to safety at the health centre. The minister said that the government condemns such harsh actions, and insisted that society must reveal any kind of violence against children while promising that the law will take its course. Source: Radio One habari, "Waziri wa Maendeleo ya Jamii, Jinsia na Watoto," <http://ippmedia.comipp/radio1/2008/08/09/120247.html> Accessed: 11/08/2008, p. 1.

themselves from the virus,[82] which in turn facilitates the spread of HIV. The suggestion to "Be faithful" is another prevention approach which seems to demand only one gender (women) to be faithful because socially this is assumed not to apply to men. Research has found that 60-80 percent of African women who are HIV positive and are in monogamous marriages have been infected by their marital spouses.[83] This reality prevails because of the patriarchal ideology which works in favour of men at the expense of women.

The Abstain, Be faithful and Condomise (ABC) strategy is an example therefore of a gender-neutral strategy. What I am interested in my study is whether the programmes of the diocese also promote the ABC strategy and if this is done in a gender-neutral way. Another area of interest for me is the question of what the theological beliefs which under-gird the promotion of the ABC strategy are, and how these can be engaged with bearing in mind the gendered limitations of such strategies.

2.2.3 Programmes that are gender sensitive

According to Rao Gupta, gender sensitive programmes respond to the needs of men and women in relation to their gender and sexuality.[84] The provision of condoms designed for both men and women is one of the practical actions that fall under these programmes.[85] Initially in Africa, only male condoms were accessible and available but over time female condoms have been made available to enable women to have control over their own sexuality. However, it is only through a mutual relationship of respect between sexual partners that the issue of condom use can be effective, because of the abovementioned reasons of gender inequality. This raises an important question for my study: are the HIV and AIDS programmes of the ELCT Northern Diocese gender sensitive enough to

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[82] Dube, "Grant Me Justice," p. 9. See also Mpine Qakisa, "Let's Talk about Sex: Reaching Young People through the Media in the Age of AIDS," in *Journal of Theology for Southern Africa,* 114, (November 2002), p. 81. Beverley Haddad, "Gender Violence and HIV/AIDS: A Deadly Silence in the Church," in *Journal of Theology for Southern Africa*, 114, (November 2002), p. 93.
[83] Commonwealth Secretariat, *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach,* London: Commonwealth Secretariat, 2002, p. 26. See also Tanja Muller, *HIV/AIDS gender and rural livelihood in sub-Saharan Africa,* Wageningen: Wageningen Academic Publishers, 2005, p. 26. Dube, "Grant Me Justice," p. 9.
[84] Rao Gupta, "Gender, Sexuality, and HIV/AIDS," p. 5.
[85] UNAIDS, "Facing the Future together," p. 7, 47.

include male and female condoms in their programmes? If not, what is the theological reasoning behind the refusal of such gender sensitive interventions?

A further strategy of the gender-sensitive programmes is geared toward helping women to engage in income generating activities that will lead them to self reliance and to avoid dependence on men. In addition, the availability of health facilities where women can easily access services is also part of these programmes. Meanwhile, another gender sensitive approach is the imparting of education to men which is based on their roles as decision makers in their relationships with women.[86] Such programmes are intended to help men to make safer and better decisions to protect themselves, their sexual partners as well as their children. Other important questions which this raises for my study are: to what extent are the HIV and AIDS programmes of the ELCT Northern Diocese involved in the economic empowerment of women? Do the HIV and AIDS programmes of the diocese also promote the availability of health facilities for women? Are the programmes of the diocese involved in encouraging men to take responsibility for themselves and for their families? Finally, if the programmes are not engaged in these gender-sensitive measures, what are the theological reasons which prevent this?

2.2.4 Programmes that aim at empowerment

Rao Gupta points out that programmes that aim at empowerment focus on women,[87] due to their vulnerability to HIV, to health services and infection, which is reinforced by social, cultural, economical and religious factors. Rao Gupta identifies six sources of empowerment for women which include education and information about their bodies and sex; communication skills about sex and how to use condoms; access preventive measures such as the female condom; access to economic resources and the right to own property; social support; and the opportunity to participate in decision-making forums at all levels of society.[88] These elements of empowerment are essential. Hence, my question is how do the HIV and AIDS programmes of the diocese focus on women and their

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[86] UNAIDS, "Facing the Future together," p. 47.
[87] Rao Gupta, "Gender, Sexuality, and HIV/AIDS," p. 6.
[88] Commonwealth Secretariat, *Gender Mainstreaming in HIV/AIDS*, p. 35, 36, 37. See also Mpine Qakisa, "The Media representation of Women and HIV/AIDS: How it affects preventative messages," in *Missionalia,* 29, 2, (August 2001), p. 316. Usdin, *The No-Nonsense guide to HIV/AIDS*, p. 116.

particular needs. If there is no focus on women and their empowerment why is this so, and what are the theological beliefs which prevent such empowerment?

2.2.5 Programmes that are transformational

The final category identified by Rao Gupta is that of transformational programmes,[89] which aim at changing gender roles and creating equal power relations between men and women at personal as well as at community and societal levels.[90] Through these programmes, structures, laws and policies are transformed in order to work in favour of women, such as those dealing with domestic violence and marital rape, property ownership and inheritance. The transformation is also geared towards empowering women to have access to resources, credit, employment and other opportunities that will enable them to attain independence and autonomy. In terms of my study the important question for me is, are the HIV and AIDS programmes of the diocese geared towards the transformation of the status quo of the church, state and society or are they simply addressing the symptoms of the inequalities which fuel the spread of HIV?

2.3 Luther's theologies

A second theoretical framework I have chosen for this study involves Luther's theologies. Given that the church under study is Lutheran, I want to assess to what extent the beliefs and practices of the church are informed by Luther's theologies, as expressed in the church's programmes on HIV and AIDS. There are three particular theologies of Luther that are important for my purposes. The first is his theology of suffering; the second is his theology of healing and the third his theology regarding gender.

2.3.1 Luther's theology of suffering

Luther's theology of suffering[91] provides a sound theological framework for assessing the theological beliefs which under-gird the programmes of the diocese. Luther's theology of suffering was largely based on his experiences of the bubonic plague in the 1500's. His theology of suffering focused mainly on the issue of care-giving as a central

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[89] Rao Gupta, "Gender, Sexuality, and HIV/AIDS," p. 5.
[90] UNAIDS, "Facing the Future," p. 48.
[91] von Loewenich, *Luther's Theology of the Cross*. See also Althaus, *The Theology of Martin Luther*. Thiemann, "Luther's Theology of the Cross," Dau, *Suffering and God."*

mission of the church. While his theology of suffering is helpful to gauge the extent of care-giving that is present in the ELCT Northern Diocese, at the same time, this study will critique Luther's own lack of gender awareness in the area of care-giving during the crisis of the bubonic plague.

Luther's theology of suffering is based on his theology of the cross, the latter being captured in his words, "Now it is not sufficient for anyone, and it does him no good to recognize God in his glory and majesty, unless he recognizes him in the humility and shame of the cross."[92] The statement affirms that God is found on the cross through the suffering and death of Christ.

Six months after Luther nailed his Ninety-Five Theses on the Castle Church door in Wittenberg on 31 October 1517,[93] he went to Heidelberg to address some of the controversy surrounding his Theses.[94] In Heidelberg he gave a lecture, contrasting the theology of glory with the theology of the cross, which was known as the Heidelberg Disputation.[95] Luther stated that the theology of glory seeks to know God directly in his divine power, glory and wisdom, while the theology of the cross seeks out God where he has hidden himself, in his suffering and in all that which the theology of glory considers to be foolishness and weakness.[96] Luther compared Christians who advocate for the theology of glory with Moses who asked God, "Show me your glory." God answered him (and them) that: "You cannot see my face; for no one shall see me and live" (Ex. 33: 18-

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[92] Martin Luther, "Heidelberg Disputation," in Harold Grimm (ed), *Luther's Work*, Vol. 31, Philadelphia: Muhlenberg Press, 1957 p. 52, 53. See also, von Loewenich, *Luther's Theology of the Cross*, p. 29.

[93] Martin Luther, "Ninety-Five Theses or Disputation on the Power and Efficacy of Indulgences," in Harold Grimm (ed), *Luther's Works*, Vol. 31, Philadelphia: Muhlenberg Press, 1957, p. 19. See also Martin Luther, "The Ninety-Five Theses (1517)," in Timothy F. Lull (ed), *Martin Luther's Basic Theological Writings*, 2nd edition, Minneapolis: Fortress Press, 2005, p. 40. Walther von Loewenich, *Martin Luther: The Man and His Work*, Minneapolis: Augsburg Publishing House, 1982, p. 109.

[94] Luther, "Heidelberg Disputation," p. 37. See also Martin Luther, "Heidelberg Disputation," in Timothy F. Lull (ed), *Martin Luther's Basic Theological Writings*, 2nd edition, Minneapolis: Fortress Press, 2005, p. 47. James Atkinson, *Martin Luther and the Birth of Protestantism*, Atlanta: John Knox Press, 1968, 157.

[95] Dau, *Suffering and God*, p. 96. See also Althaus, *The Theology of Martin Luther*, p. 25. Martin Luther's doctrine of love, suffering, faith and true ministers of God's Word, <http://perichorus.wordpress.com/2009/12/18/martin-luther%E2%80%99s-doctrine-of-lov...>12/08/2009, p.1.

[96]Althaus, *The Theology of Martin Luther*, p. 27. Thiemann, "Luther's Theology of the Cross," p. 232.

23).[97] Luther further claimed that Christians who embrace a theology of glory are those who have not taken into account God's response to Moses that he could not see his face but rather his back. To see God's back is what Luther calls the "theology of the cross," which views that God is found in the weak, foolish, rejected and despised things of this world.[98] In situations of crisis such as sickness, death or suffering, it is only through strong faith that Christians can understand God, but a God who shares their pain is more accessible than one who remains high in glory.

Contrary to the theology of glory, the theology of the cross views humanity as being called to rely on Christ for redemption since people cannot save themselves.[99] In this regard, the task of the theology of the cross is to destroy the self-confidence of humanity in order that they will acknowledge that they need God to do everything for them, a state which leads an individual from moralistic to pure receptivity.[100] Luther argued that the theologians of glory regard the cross as evil, while the friends of the cross accept the cross because through it, salvation is assured.[101]

Luther further emphasized that the theology of the cross has to start at the cross where God is both revealed and hidden.[102] Luther made clear that the hiddenness of God is visible only within the context of faith. Without the true eye of faith human beings cannot see the glory, the knowledge, righteousness and the salvation of God which is both revealed and hidden in the humiliation, weakness and the blame of the cross of Christ. God therefore identifies Godself with the suffering and weakness at the cross. This implies that "God must then be sought as the one who is always active but also always hidden in the cross of Christ."[103] Thus, God cannot be found anywhere except at the cross. The hiddenness of God comes about when individuals are in pain and suffering,

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[97] Althaus, *The Theology of Martin Luther*, p. 25.
[98] Martin Luther's doctrine of love, suffering…" p. 2. See also von Loewenich, *Martin Luther: The man and His Work*, p. 124.
[99] Althaus, *The Theology of Martin Luther,* p. 27.
[100] Althaus, *The Theology of Martin Luther*, p. 28.
[101] Althaus, *The Theology of Martin Luther*, p. 29.
[102] Dau, *Suffering and God,* p. 96. Daniel Louw, *Meaning in Suffering: A theological reflection on the cross and the resurrection for pastoral care and counselling,* Berlin: Peter Lang, 2000, p. 76.
[103] Dau, *Suffering and God*, p. 96.

leading them to feel as if God has abandoned them or as if God does not care about their situation. Job, the Psalmist and prophet Isaiah are examples of biblical people who realized the presence as well as the hidden state of God in times of pain and suffering (Job. 13:24, Ps. 44:24 and Is. 45:15).[104] A Christian who is in the midst of severe suffering or grief can easily feel that God is far away or is not concerned about their struggle, in particular if they view God through the theology of glory. Pastoral care and counselling is therefore crucial to guide individuals to deal with their situation.

Luther built his theology of the cross on Paul's teachings in 1 Corinthians 1:18 ff,[105] thus making his theology a biblical message rather than a philosophical one, as people might have thought it to be. The theology of the cross is all about God's redemptive work for his creation through the suffering and death of Christ at the cross, and about God's participation in human suffering.[106]

In relation to human suffering, Luther's theology of the cross underlines that the crucified God identifies with our suffering and pain.[107] Although God seems to be hidden or far away from the people during their difficult time, he is familiar with their pain, suffering and struggles and is always on their side even though through their human eyes they may not realize God's presence. Another important issue concerning the theology of the cross is that Christians are required to look at the cross of Christ as the centre where God's work of salvation for the world was fulfilled.[108] This realization will lead Christians to humble themselves in order to receive strength from God who strengthens the weak and helpless in times of suffering. Suffering is inevitable in this world and issues such as HIV and AIDS and other chronic diseases, war and natural disaster are part of human life. However, through the theology of the cross those who suffer gain the strength to cope.

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[104] Dau, *Suffering and God*, p. 96. See also Klaus Nurnberger, *Martin Luther's message for us today: A perspective from South*, Pietermaritzburg: Cluster Publications, 2005, p. 20.
[105] Althaus, *The Theology of Martin Luther*, p. 34. See also von Loewenich, *Luther's Theology of the Cross*, p. 22.
[106] Althaus, *The Theology of Martin Luther,* p. 26, 27.
[107] Dau, *Suffering and God*, p. 98.
[108] Dau, *Suffering and God*, p. 99.

Since God can be found only at the cross of Christ, it is an indication that God is in the midst of suffering, including the suffering of people living with HIV and AIDS (PLWHA). In this case, the suffering of people who are HIV positive is associated with the hidden God who is nonetheless present. In sum, Luther had a remarkably developed theology of suffering which he drew from his theology of the cross and which he cast in opposition to a theology of glory. Given that the church in my study is Lutheran, I wish to know to what extent Luther's theology of suffering informs the HIV and AIDS programmes of the diocese and to what extent Luther's other theologies, for example his theologies on healing and gender, contribute to the ways in which the programmes are developed.

2.3.2 Luther's theology of healing

In Luther's time, sickness played a large part in the lives of people, for example, there was a high rate of tuberculosis during the sixteenth century.[109] Luther argued that some ailments were related to sexually transmitted diseases, while others were mental and spiritual, and others again were caused by poor diet and sanitation, such as dysentery, colic and jaundice.[110] In addition, he noted that the situation was made worse because treatments to cure some of the diseases were unavailable. The most threatening disease of the time was the bubonic plague which killed millions of Europeans. In such situations, people are not only hurt physically but also emotionally and spiritually, hence they are in need of healing. Luther offered various insights on healing in order to alleviate people's pain and suffering.

The primary instruction which Luther gave as a healing remedy was the use of medicine in that individuals were required to consult medical practitioners.[111] He therefore maintained: "Resort to medicine is desirable…it is well that physicians and nurses do what they can."[112] Luther believed that medicine plays a significant role in bringing healing, which is why during the bubonic plague; he often insisted that individuals must

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[109] Theodore Tappert, "General Introduction," in Theodore Tappert (ed), *Luther: Letters of Spiritual Counsel,* London: SCM Press, 1955, p. 16.
[110] Tappert, "General Introduction," p. 16, 17.
[111] Tappert, "General Introduction," p. 17.
[112] Tappert, "General Introduction," p. 17.

ensure that they took their medication as prescribed. Commenting on the use of medicine from a theological stance, Daniel Louw contends that "Medicine is a sign which points indirectly towards salvation in Christ and God's sovereignty over all of creation."[113] Medication not only heals the body but the wholeness of the person also. In most cases, individuals who have been very sick and who have recovered after receiving medical care tend to acknowledge the power of God in the entire process of their healing. Such a sentiment therefore confirms Louw's argument that God intervenes in the lives of the people during their sickness. In this view, medicine is God's gift to their people as it promotes life for many.

A second point made by Luther with regard to the healing process was his emphasis that Christians have the obligation to provide care to their sick relatives and neighbours.[114] He claimed that by so doing, we are serving Christ himself. For Luther, care-giving was the fulfilment of God's command that we ought to love one another as Christ loves us. Luther's stance is crucial and relevant to our context as far as HIV and AIDS is concerned.

A third point highlighted by Luther with regard to healing is that it is necessary to visit the sick, an action which by its nature brings healing to the ill individuals.[115] Luther described visiting the sick as one of the humanitarian duties which Christ commanded Christians to do for their neighbours who are afflicted by illness. To visit someone who is sick offers them spiritual and emotional healing as well as comfort. It assures the afflicted that there are other people besides their family members who are also concerned about their situation. As Patricia Fresen has put it, "Our best or only possible response may be to be there, to stay with the person. And we know how difficult this "being there" can be,

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[113] Daniel Louw, *Illness as crisis and challenge: Guidelines for pastoral care*, Doornfontein: Orion, 1994, p. 65.
[114] Martin Luther, "Advice in Time of Pandemic and Famine: To John Hess," in Theodore Tappert (ed), *Luther: Letters of Spiritual Counsel,* London: SCM Press, 1955**,** p. 232, 233. See also Luther, "Whether one may flee from a deadly plague," p. 122. Carl Reuss, "Health Service," in Julius Bodensiek, *The Encyclopedia of Lutheran Church*,   Philadelphia: Fortress Press, 1965, p. 991.
[115] Martin Luther, "Comfort for the Sick and Dying," in Theodore Tappert (ed), *Luther: Letters of Spiritual Counsel*, 1955, p. 26, 27. Morton Kelsey, *Healing and Christianity: A Classic Study*, Minneapolis: Augsburg Fortress**,** 1995, p. 175.

how demanding of us, yet how important, how comforting and even healing, for the person who is suffering."[116] The initiative to visit the person is itself a commitment as it is time demanding.

A fourth device for healing the sick highlighted by Luther is prayer and the laying of hands upon the sick person. Luther gave this instruction with regard to mental illness which did not respond to medication. Responding to a pastor who consulted him for guidance on how to deal with such a problem, Luther said:

> Go to him with the deacon and two or three good men. Confident that you, as pastor of the place, are clothed with the authority of the ministerial office, lay your hands upon him and say, "Peace be with you, dear brother, from God our Father and from our Lord Jesus Christ." Thereupon repeat the Creed and the Lord's Prayer over him in a clear voice, and close with these words: "O God, almighty Father, who hast told us through thy Son, Verily, verily, I say unto you, "Whatsoever ye shall ask the Father in my name, he will give it you," who hast commanded and encouraged us to pray in his name, "Ask, and ye shall receive;" and who in like manner hast said, "Call upon me in the day of trouble: I will deliver thee, and thou shalt glorify me," we unworthy sinners, relying on these thy words and commands, pray for thy mercy with such faith as we can muster. Graciously deign to free this man from all evil, and out to nought the work that Satan has done in him, to the honor of thy name and the strengthening of the faith of believers; through the same Jesus Christ, thy Son, our Lord, who liveth and reigneth with thee, world without end. Amen." Then, when you depart, lay your hands upon the man again and say, "These signs shall follow them that believe; they shall lay hands on the sick, and they shall recover.[117]

Luther's instruction highlights two important elements. The first aspect is the fact that the pastor was supposed to lay his [sic] hands upon the sick and pray by using the prescribed words. The second important feature in Luther's instructions to the pastor was that he (the pastor) was to go to the sick person together with other lay people.

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[116] Patricia Fresen, "Responsibility and Caring for One Another," in Stuart Bate (ed), *Responsibility in a Time of AIDS: A Pastoral Response by Catholic Theologians and AIDS Activists in Southern Africa,* Pietermaritzburg: Cluster Publications, 2003, p. 63.
[117] Luther, "Comfort for the sick and dying," p. 52.

Morris Maddocks argues that the laying on of hands has a theological and psychological foundation.[118] The theological basis is that it is an act of adoption. He gives the example that when a teacher of the law (a rabbi) enrols learners for a subsequent course of study; he lays on his hands upon them. Similarly, the act of commissioning individuals for the ministry of the church, which is preceded by prayer and the laying on of hands, is also an act of adoption. Meanwhile, the psychological aspect of the laying on of hands has to do with the act of touch which expresses love.

In sum, Luther's theology of healing was based on four aspects. The first was medication, the second was caring for the sick, the third was visiting the sick, and the fourth is the laying on of hands and prayer. I am interested which aspects of Luther's theology of healing are being taken up by the HIV and AIDS programmes of the diocese. For example, in terms of medication, how are the programmes involved in the distribution of medication; or in terms of care-giving, who is responsible for providing such care and is this gendered?

Furthermore, in terms of visiting the sick, to what extent are lay people being empowered to participate in these forms of care and finally with regard to pastoral care, how are the programmes empowering both the ordained and the lay people and both men and women to participate? Having examined, as part of the second theoretical framework employed in the study – the theology of healing, I now turn to the final aspect of Luther's theology that is important for this study, namely Luther's theology on gender.

2.3.3 Luther's theology of gender

In Luther's theology, women are regarded as weaker vessels by nature.[119] This weakness is derived from his interpretation of the way in which Eve was deceived by the serpent. While Luther admitted that both man and woman are created in God's image, he was convinced that woman is not equal to man, contending that:

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[118] Morris Maddocks, *The Christian Healing Ministry,* London: SPCK, 1981, p. 121.
[119] Karant and Wiesner, *Luther on Women,* p. *15. See also* Wiesner, "Luther and Women," p. 126, 131. Michelle A. Gonzalez, *Created in God's Image: An Introduction to Feminist Theological Anthropology*, Maryknoll: Orbis Books, 2007, p. 53.

The woman appears to be a somewhat different being from the man, having different members and a much weaker nature. Although Eve was a most extraordinary creature – similar to Adam so far as the image of God is concerned, that is, in justice, wisdom, and happiness – she was nevertheless a woman. For as the sun is more excellent than the moon (although the moon, too, is a very excellent body), so the woman, although she was a most beautiful work of God, nevertheless [she] was not [the] equal of the male in glory and prestige…The male is like the sun in heaven, the female like the moon, the animals like stars, over which sun and moon have dominion. [120]

A woman is thus a lesser human in Luther's eyes. To illustrate the superiority of men and the inferiority of women, Luther compared man to the sun which shines everywhere at once and woman with the moon which gives light to a particular place for a short time and then disappears. The subjection of woman was to a degree assumed from the time of her creation onward, but was intensified after the fall, despite the fact that both man and woman disobeyed their Creator. Luther ignored Adam's weakness with regard to the fall, placing all the blame on Eve, which echoed the views of the Church Fathers.[121]

Building on the Epistle of Peter, which claims that the woman is the weaker sex (1 Pet. 3:7), Luther stipulated that the weakness of woman is based on their bodies and spirit, therefore he cautioned men (husbands) that:

A man is also God's vessel, but he is stronger than a woman. She is weaker physically and also more timid and downhearted in spirit. Therefore you should deal with her and treat her in such a way that she can bear it. You must take care of her as you take care of another tool which you work. For example, if you want to have a good knife, you must not hack into stone with it...You must use your authority; for you are her husband to help, support and protect her, not to harm her.[122]

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[120] Martin Luther, "Chapter One," in Jaroslav Pelikan (ed) Lectures on Genesis Chapters 1-5: *Luther's Works,* Vol. 1, Saint Louis: Concordia Publishing House, 1958, p. 68, 69.
[121] Lisa Isherwood and Elizabeth Stuart, *Introducing Body Theology: Introductions in Feminist Theology*, Ohio: The Pilgrim, 1998, p. 18, 19.
[122] Martin Luther, "Sermons on the First Epistle of St. Peter," in Jaroslav Pelikan (ed), *Luther's Works: The Catholic Epistles*, Vol. 30, St. Louis: Concordia Publishing House, 1967, p. 91, 92.

This reveals that Luther's perception of women is based on paternalism. I agree with Luther that husbands are not supposed to harm their wives, but rather to support, help and protect them. However this is because they both bear the image of God and not because wives are a tool which can break when wrongly used. Two points regarding Luther's views need to be made here. On one hand, the physical weakness which Luther refers to is debatable. On the other hand, Luther's insistence that marriage and motherhood are prerequisites for women since it is their only way to fulfil their God-given function is also questionable.[123] For Luther, marriage and childbearing are termed as a vocation (a call) to indicate that people are called by God to enter into these states and that they are not a matter of choice.[124] He further asserted that even death due to childbirth is God's will.[125] In conclusion, while Luther's theology of suffering and healing may offer the church resources on which to build their theologies which inform their HIV and AIDS programmes, his theologies with regard to gender may be seen as a stumbling block rather than a resource. In view of this, the question that is important for my study is: to what extent has Luther's theology on gender impacted the various programmes of the church?

Thus far, the tools of analysis which I have described for my study have been firstly sociological and then theological. I now turn to a tool that combines both the sociological and the theological aspects in ways that contribute to a deeper analysis of the gendered nature of the HIV and AIDS programmes of the diocese under study. This theoretical tool termed African feminist cultural hermeneutics has been developed by Kanyoro.[126]

2.4 Feminist theologies and African feminist cultural hermeneutics

African feminist cultural hermeneutics, which is the third theoretical framework, is important for this study because of its engagement with a number of cultural issues

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[123] Wiesner, "Luther and Women," p. 127.

[124] Karant and Wiesner, Luther on Women, p. 137, 138. Since Luther regarded childbearing as the most important function in marriage, he then advocated for divorce in case of infertility. It is also notable that Luther was convinced that women were not called to preach, teach or lead but only to bear children, p. 171.

[125] Barbara J. MacHaffie, *Reading in Her Story: Women in Christian Tradition*, Minneapolis: Fortress Press, 1992, p. 68.

[126] Kanyoro, *Introducing Feminist Cultural Hermeneutics.* See also Mercy Oduyoye, *Introducing African Women's Theology,* Sheffield: Sheffield Academic Press, 2001.

which contribute to the spread of HIV. Kanyoro's African feminist cultural hermeneutics is a theory that asserts that we need to be critical of those aspects of African culture which are life-denying while reclaiming those aspects which are life-giving. This becomes important when analysing the cultural practices among the Chagga that are potentially dangerous in the contexts of HIV, but it is also important in the development of strategies to reclaim cultural practices which can enhance life.

Feminist cultural hermeneutics, which focuses on culture as a source of theology is one of seven key features of African women's theologies.[127] African women's theologies "belong to a wider family of feminist theology which is further categorized as liberation theology. Both theologies are different varieties of Christian theology, which acquired their names on the basis of context and approach."[128] I will first examine the origins of feminism/feminist theology, which will then help us to understand African women's theologies and the tool they use to analyze culture, i.e. feminist cultural hermeneutics.

2.4.1 Feminism and feminist theologies

Anne Clifford defines feminism as "a movement seeking the liberation of women from all forms of sexism."[129] This highlights and addresses the fact that women are not regarded as being equal to their male counterparts within the family and society at large. This thinking awakened women to organize themselves into a movement to fight against this discrimination and oppression, a fight which would later accord them the right to participate in public life. The word "feminism" was firstly used by Hubertine Auclert in 1882 to name the struggle of women in North America and Europe to gain political rights.[130] This struggle was characterized as "first wave feminism" which took place between the 1880s and the 1920s.[131]

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[127] Isabel Phiri and Sarojini Nadar, "What's in a Name" - Forging a theoretical Framework for African Women's Theologies," in *Journal of Constructive Theology*, 12, 2, (2006), p. 11.
[128] Isabel Phiri, "African women's theologies in the new millennium," in *Agenda*, 61 (2004), p. 16. See also Isabel Phiri, "Southern Africa," in John Parratt (ed), *An Introduction to Third World Theologies*, New York: Cambridge University Press, 2004, p. 151.
[129] Anne Clifford, *Introducing Feminist Theology*, Maryknoll: Orbis Books, 2002, p. 16, 17.
[130] Clifford, *Introducing Feminist Theology,* p. 11. See also Rakoczy, *In Her Name: Women Doing Theology*, Pietermaritzburg: Cluster Publications, 2004, p. 12.
[131] Jane Pilcher and Imelda Whelehan, *Fifty Key Concepts in Gender Studies*, London: SAGE Publications, 2004, p. 52.

In the 1960s, "second wave feminism" emerged again in Europe and North America. It is during this wave that feminist theology was born. Feminist theology emerged after Christian women began to reflect on the issues raised by women in the secular feminist movement in the 1960s ("second wave feminism").[132] Rosemary Radford Ruether, one of the pioneers of feminist theology argues that:

> Feminist theology takes feminist critique and reconstruction of gender paradigms into the theological realm. [Feminist theologians] question patterns of theology that justify male dominance and female subordination, such as exclusive male language for God, the view that males are more like God than females, that only males can represent God as leaders in church and society, or that women are created by God to be subordinate to males and thus sin by rejecting this subordination.[133]

Ruether's statement reveals the anger of, and critiques by women concerning the assumptions of male superiority in the entire structure of the church, ranging from the language of the Bible which is sexist, to the notion that men are more like God, and that they then have the right to lead the church and society. This ideology has undermined the visibility of women in religion and the life of the church for centuries. Furthermore, feminist theologians were also concerned about the reconstruction of "the basic theological symbols of God, humanity, male and female, creation, sin and redemption, and the church, in order to define these symbols in a gender-inclusive and egalitarian way."[134]

Generally, the main task of feminist theology was and is to respond to the gender injustice in the Bible, in the church and in society.[135] In the process of analyzing and interpreting the Scripture, some of the feminist theologians left the church because they found the Bible and the church to be so oppressive.[136] Meanwhile those who remained in

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[132] Phiri, "African women's theologies in the new millennium," p. 16.

[133] Rosemary R. Ruether, "The emergence of Christian feminist theology," in Susan Parsons (ed), *The Cambridge Companion to Feminist Theology*, New York: Cambridge University Press, 2002, p. 3.

[134] Ruether, "The emergence of Christian feminist theology," p. 4.

[135] Musimbi Kanyoro, "Feminist/Womanist/ Mutherista/ Women's Focus on Theology: Analysis," in Prasanna Kumari (ed), *Feminist Theology: Perspectives and Praxis*, Chennai: Gurukul Summer Institute, 1999, p. 264.

[136] Kanyoro, "Feminist/Womanist/Mutherista/Women's Focus on Theology," p. 264.

the church continued to do theology using the Bible as the source of their theology. In the course of their interpretation, they began to respond to biblical passages that are used by the church to oppress and exclude women.

In the late 1970s, so-called "third wave feminism" was developed. This third wave of feminism was a response to varied experiences of women from other parts of the world since the experience of white, middle class women in Europe and America was previously considered to be the norm for all women.[137] For instance, it was now recognized that the experiences of Hispanic and African American women in the USA were and are different from that of white middle class women, despite the fact that they are living in the same country. The former are subjected to more oppression and discrimination due to their racial and economic status. This awareness resulted in the formation of various women's theologies, not only for African American and Hispanic women in the USA, but also for women in Asia, Africa and Latin America. We now turn to one such theology, namely African women's theologies which were developed by African women.

2.4.2 African women's theologies

African women's theologies are part of feminist theology and are a branch of liberation theology initiated by Christian women in Africa[138] who named their movement "The Circle of Concerned African Women Theologians (hereafter, the Circle)."[139] The Circle was inaugurated in September 1989 in Accra, Ghana at a meeting which was attended by more than seventy African women theologians,[140] and more than two hundred

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[137] Rakoczy, *In Her Name: Women Doing Theology,* p. 13.
[138] Phiri, "African women's theologies in the new millennium," p.16.
[139] Mercy Oduyoye, "THE CIRCLE," in Mercy Oduyoye and Musimbi Kanyoro (eds), *Talitha Qumi!: Proceedings of the Convocation of African Women Theologians 1989*, Accra: SWL Press, 2001, p. 10.
[140] Oduyoye, "THE CIRCLE," p. 10. See also Nyambura Njoroge, "Talitha Cum! to the new Millennium: A Conclusion," in Nyambura Njoroge and Musa Dube (eds), *Talitha Cum! Theologies of African Women*, Pietermaritzburg: Cluster Publications, 2001, p. 247. Kanyoro, "Engendered Communal Theology: African Women's Contribution to Theology in the 21st Century," in Nyambura J. Njoroge and Musa W. Dube (eds), *Talitha Cum! Theologies of African Women*, Pietermaritzburg: Cluster Publications, 2001, p. 169. Isabel Phiri, *The Girl Child, Women, Religion and HIV/AIDS in Africa: Gender Perspectives: Report of the 4th Pan African Conference of the Circle of Concerned Women Theologians,* Yaounde, Cameroun, September 2-8, 2007, p. 4.

churchwomen from Ghana.[141] Addressing the participants during the inauguration of the Circle, Mercy Oduyoye[142] urged the church to develop a "two-winged" theology, through which both men and women could communicate with God.[143] Oduyoye's statement challenges the conservative assumptions and approaches which for centuries have excluded women from the life of the church, particularly in ordained ministry and leadership positions. African women's theologies, like other liberation theologies elsewhere in the world, have emerged in response to oppressive experiences in a particular context. In this case, they have emerged in response to the oppression of women in Africa, which is rooted in patriarchal structures in society and the church. As noted earlier, women's experiences differ from one society or region to another because of different backgrounds, nationalities, cultures and religions. The theme of the above-mentioned conference, "Daughters of Africa Arise"[144] affirms the women's anger and indicates the initiative of African women to take a lead in exposing and challenging the oppressive elements which undermine their dignity.

Why African women's "theologies" are in plural form is explained by Phiri who argues that:

> African women theologians want to acknowledge that even within Africa, there is diversity of women's experiences due to differences in race, culture, politics, economy and religion. Despite the differences in terminology, all women would like to see the end of sexism and the establishment of a more just society of men and women who seek the wellbeing of other.[145]

Kanyoro contends that: "These concerned women are engaged in theological dialogue with the cultures, religions, sacred writings and oral stories, which shape the African

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[141] Musimbi Kanyoro, Beads and Strands: Threading More Beads in the story of the Circle," in Isabel Phiri, Devakarsham Govinden & Sarojini Nadar (eds), *Her-Stories: Hidden Histories of Women of Faith in Africa,* Pietermaritzburg: Cluster Publications, 2002, p. 17.

[142] Mercy Amba Oduyoye, a Ghanaian, theologian and the founder of the Circle, has written widely on issues related to women's experiences in Africa. She is currently the director of the Talitha Qumi Centre which is part of the Institute of African Women in Religion and Culture based in Ghana. She has held this post since her retirement from the World Council of Churches (WCC) in Geneva where she last served as Deputy General Secretary.

[143] Njoroge, "Talitha Cum! to the new Millennium: A Conclusion," p. 247.

[144] Kanyoro, "Beads and Strands," p. 20. See also Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 5.

[145] Phiri, "African Women's theologies in the new millennium," p. 16.

context and define the women of this continent."[146] Religion, culture and the Scriptures are highlighted as the aspects that dominate the women's theological thinking since these elements contribute negatively to women's lives as they have been used to oppress and exclude women in the church and society. However, African women theologians are aware that not everything in culture and religion is bad. They contend that whatever is good in culture and religion will be encouraged and maintained; while that which diminishes and threatens the lives of humanity will be challenged.[147]

The content of the women's writings and the methodology employed are outlined by Phiri who says:

> African women's theologies are a critical, academic study of the causes of women's oppression, particularly a struggle against societal, cultural and religious patriarchy… [and are] committed to the eradication of all forms of oppression against women through a critique of the social and religious dimensions both in African culture and religions. African women's theologies take women's experiences as a starting point, focusing on the oppressive areas of life caused by injustices such as patriarchy, colonialism, neo-colonialism, racism and globalization.[148]

After having looked at the formation and the tasks of African women's theologies, we will explore feminist cultural hermeneutics, which is one of the three frames of reference for this study.

2.4.3 Feminist cultural hermeneutics

Since the writings of African women theologians focus on the articulation of negative elements in culture and religion which oppress and dehumanize women, feminist cultural hermeneutics is then used as a tool to analyze and critique those aspects which pose a hazard to women's health. Interestingly, culture, which plays a significant role in oppressing women, can also be used as a tool to scrutinize its own oppressive nature in order to bring liberation to women. Isabel Phiri and Sarojini Nadar state that the term "hermeneutics" is used in the biblical studies discipline, thus its usage in the context of

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[146] Kanyoro, "Beads and Strands," p. 16.
[147] Phiri, "African women's theologies in the new millennium," p. 17.
[148] Phiri, "African women's theologies in the new millennium," p. 20.

feminist cultural hermeneutics serves to create a dialogue between the culture of the Bible and the diverse cultures in Africa.[149]

In concluding this section, the question of what is significant about the theories of feminist theology and feminist cultural hermeneutics for my study is briefly discussed. These are significant theories because they offer me tools with which to analyze the HIV and AIDS programmes of the church, and to assess to what extent they are sensitive to the contribution of culture in the matter of gender oppression that fuels the spread of HIV and AIDS.

2.5 Conclusion

The chapter explored the three theoretical frameworks of this study. The first was the gendered conceptual framework for assessing HIV and AIDS programmes, as proposed by Rao Gupta. The second described Luther's theologies. The three theologies of Luther which were of importance to this study were Luther's theology of suffering, his theology of healing and his theology with regard to gender. The third theoretical framework used in the study's analysis process, as described in this chapter, was feminist theologies, specifically African feminist cultural hermeneutics.

These three frames of reference will thus form the theoretical background to this study. They will be used to help me answer my central research questions and objectives of this study which are:

- To describe and analyze the HIV and AIDS programmes and policy of the ELCT Northern Diocese;

- To investigate whether the HIV and AIDS programmes are gender sensitive;

- To examine to what extent the theological beliefs under-girding the HIV and AIDS programmes and policy encourage a more gendered sensitive response to HIV and AIDS;

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[149] Phiri and Nadar, "What's in a Name? p. 11.

- To develop theologies that encourage relevant HIV and AIDS programmes that considers both men and women.

Before I proceed with the above objectives, it will be helpful to sketch the methodology that was employed in order to meet the objectives of this study. This will be the content of the next chapter.

CHAPTER THREE
METHODOLOGY OF THE STUDY

3.1 Introduction

Having examined the theoretical frameworks governing the study in the previous chapter, namely the gendered conceptual framework for assessing HIV and AIDS interventions; Luther's theology of suffering, his theology of healing and his theology with regard to gender; and feminist theologies and African feminist cultural hermeneutics, this chapter will underline the methods and methodology employed to collect data, and the sampling of the participants of this study. Individual in-depth interviews, participant observation and case studies were the method used in the study; this was coupled with reference to documentary sources. I will first describe the location of the study and the sampling procedure used before discussing the method used.

3.2 Location of the study

In 2009 the ELCT Northern Diocese (which is the focus of this study) had one hundred and fifty six (156) parishes and five circuits.[150] The clergy amounted to two hundred ninety four (294) and among these 20 were females. Four of the five circuits were chosen for my study because they are all dominated by the same ethnic group, namely the Chagga. The four circuits that are included in this study are: Siha, Hai, Central Kilimanjaro, and East Kilimanjaro.

The diocese runs various centres and institutions and these include: three hospitals[151] and twenty-five dispensaries,[152] one primary school for disabled children, an orphanage centre (for infants aged from one day to three years), fourteen secondary schools, one Montessori Teachers College, two higher learning institutions (Masoka and Mwika), one Bible school, four hostel and conference centres, one retreat centre, four bookshops and

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[150] KKKT-DK, "Orodha ya Wachungaji 2009," p. 1-10.
[151] Marangu Hospital, one of the three hospitals has been headed by a woman since 2005. It is a revolutionary act since the existence of the diocese.
[152] KKKT-DK, Maarifa Huongeza Uwezo: Mkutano Mkuu wa 30 wa Dayosisi SMMUCO, Masoka, 9-14 Agosti, 2008, p. 58. See also KKKT, *Kalenda 2010*, Moshi: Moshi Lutheran Printing Press, 2009, p. 22.

the Uchumi Commercial Bank (UCB) among others. These institutions are organized and supervised by boards. Moreover, there are ten departments at the head office in Moshi, which co-ordinate and plan programs that nurture the parishes and their institutions. The departments are as follows:[153] Christian Education, Mission and Evangelism, Youth, Women, Diaconal, Stewardship, Planning and Development, Communication, Auditing, Building, Health and Social Welfare. All departments are headed by men except the Women's Department.

The Diaconal Department was established at the end of 2005 as a coordinating organ of the HIV and AIDS programmes for the entire diocese, due to the enormous challenges raised by the pandemic. The Diaconal unit was originally one of the three units of the Health, Diaconal and Social Welfare Department. The others are the medical unit and the unit concerned with public health education programmes (PHEP). However, the public health education unit under this Health, Diaconal and Social Welfare Department became involved in activities related to HIV prevention, care and stigma eradication from 1993 onwards.[154]

The new separate Diaconal Department headed by Rev. Martin Burkhardt drew up a diocese master plan (the Action Plan) as a guideline for the diocese in responding to the pandemic. This action plan was presented to policy makers, all heads of the diocese's departments and institutions in a one-day seminar convened on October 25, 2006.[155] The master plan guides the diocese to adopt a multi-sectoral approach which demands all departments, institutions, circuits, parishes and individual Christians to seriously engage in addressing the consequences of HIV and AIDS, a task which had been shouldered by a single tiny unit (the PHEP unit) since 1993. Each of the circuits, departments and institutions were required to set up their own plan that was geared to prevent the spread and respond to the effects of HIV and AIDS. The establishment of the diaconal unit and a coordinator in each circuit was one of the noticeable implementations arising from this seminar, effective from 2007. The circuit diaconal coordinator is the overseer of the

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[153] KKKT-DK, *Katiba: Kanuni, Sheria na Maongozi ya Sharika - Chapisho la 2006*, p. 93, 94.
[154] Miniti za kikao cha Mradi wa Elimu ya Afya, 18/11/92 Uhuru Hostel, File-DK/23/11/29, p. 1.
[155] Burkhardt, "Mpango mkuu wa KKKT-DK Kupambana na UKIMWI na kusaidia Yatima 2006," p. 1-14.

implementation of the HIV and AIDS programmes within parishes as stipulated in the policy draft document.[156] In this view, the diaconal unit is responsible for capacity building to enable parishes to actively participate in HIV and AIDS activities. It also has the task to disseminate information, coordinate the parish activities, collect data and evaluate parish programmes or activities.

The public health education programme (PHEP) unit, which operates under the Department of Health and Social Welfare at the diocese level, is involved in co-ordinating and monitoring public health education focusing on hygiene and nutrition at circuit and parish levels. Each circuit has a PHEP unit and a coordinator. As mentioned above, since the inception of the HIV and AIDS pandemic, the PHEP unit has also been responsible in carrying out activities that alleviate the challenges posed by the pandemic. Each circuit and parish has a public health education committee.

3.3 Research sample

In order to answer the research questions, my research sample was drawn from the diocese, the PHEP unit, and the congregations who were interviewed in depth and individually. The people who were interviewed were the diocese policy makers, the implementers of the diocese's HIV and AIDS programmes (diocese/circuit primary health coordinators and zonal educators),[157] and congregants from one parish of each circuit which has an active public health education committee who range from young to old, men and women, widows and orphans and people living with HIV and AIDS (PLWHA). In total there were 49 respondents. Therefore my research sample was adequate because it drew from all levels involved in the HIV and AIDS policy and programmes: the decision making level; the implementation level and the level of recipients.

The first category of my sample consisted of the Executive Council of the diocese which represents the decision makers. The members of this council include: the bishop,

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[156] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 16.
[157] Zonal educators are also known as public health education committee members of their circuits.

assistant bishop, general secretary, deputy general secretary, treasurer, five heads of the circuits (deans) (all these officers are males), circuit layperson representatives and the chairperson for the Women and Youth Departments. Out of the thirty members, eleven participated in my study and therefore this number was an adequate representation of the Executive Council. However, only four of this group of eleven were women. The lack of equal representation of females reflects the male dominance in decision-making boards within the entire structure of the church since this is a trend in the whole diocese and circuit committees. This discrepancy means that women and their issues are at risk of being overlooked, taking into account that women and youth are the most vulnerable to HIV infection due to social, cultural, economical and religious factors.[158]

The age level of policy makers was between 45 and 67, and six of them were pastors with various positions, while five were lay men and women as mentioned above. All of these participants have attained secondary education except one man with only primary level education. Two of the females in this category were self-employed after their retirement from government positions, whereas two were still working as civil servants. Their professions range from teaching to accountancy, secretarial work to health care. The lay male was a peasant farmer. A lay man was included here because one of the circuits did not have a female on this council as mentioned earlier. For a lay-person to become a member of the diocese Executive Council means that he or she has to have been a leader in his/her parish as well as at the circuit level.

The second category of respondents in my sample of research was that of the implementers of the HIV and AIDS programmes of the diocese. This category consisted of public health education coordinators and zonal educators. Out of the five public health education coordinators, four were female nurses and one was a male coordinator. Out of the fourteen zonal educators who were interviewed, seven were males and seven were females. The public health coordinators and zonal educators were chosen because they were key people involved in HIV and AIDS work across the diocese. Overall, in the

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[158] Kessy, Mallya and Mashindano, "Tanzania," p. 217. See also Petronilla Samuriwo, "Vulnerable Groups," in AIDS Law Project, *Gender and HIV/AIDS: A Training Manual for Southern African Media and Communicators*, Johannesburg: AIDS Law Project, n.d, p. 101.

above category of respondents there were more women than men. Of interest to this study is that while the category of decision makers at a diocese level is predominantly male, the implementers of the HIV and AIDS programmes are mostly women.

All of the public health education coordinators had secondary education except one, and their ages ranged from 44 to 60 years. Similarly, the zonal educators had different levels of education. Seven out of the fourteen had acquired secondary education of which three were women, and seven had primary school education of which four were women. The age range of the zonal educators was 34 to 68. Since being a zonal educator is a voluntary task, the participants had various professions in the government and leadership positions in the church. Some of them were church elders in their respective parishes. They had varied professions including health care, veterinarian, parish worker, pastor, evangelist and peasant.

A third category in my research sample was the congregants. The group of congregants was divided into four categories. The first group consisted of PLWHA. Thus, four HIV positive females and three HIV positive males were interviewed. Three of the women were widows while the others were with their partners, who were also HIV positive. The inclusion of PLWHA in this study was an affirmation that HIV and AIDS exists within the church and not only outside the church. In other words, some church members are living with the virus and therefore a response from the church as the body of Christ is required. The age group of PLWHA was 34 to 51. Their age affirms the studies, which state that many HIV-positive individuals in Tanzania as well as other parts of Africa are infected during their reproductive years.[159] The education level of all individuals of this category except one was up to primary school level. All were involved in small scale business and farming to earn their living. Only one of them held a position of responsibility in the church as the leader of a group of PLWHA in his parish.

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[159] Kessy, Mallya and Mashindano "Tanzania," p. 217. See also Alan Whiteside and Clem Sunter, *AIDS: The Challenge for South Africa*, Cape Town: Human Rousseau, 2000, p. 74.

The second group consisted of older people. Three of them were females and one was male. They were appointed by their parishes because of their involvement with people infected and affected by HIV and AIDS. The age range of the older people among the category of congregants was 50 to 66 years old. One of the women was the chairperson of the Women's Department in her parish and a health worker in a government institution. The two other women were counsellors of PLWHA in their parishes. They were also health practitioners in government hospitals but one of them had recently retired and was running her own dispensary close to her homestead. The male older person was a parish fieldworker responsible for matters pertaining to orphans within the parish.

The third group of the sample of congregants consisted of young people. Despite the fact that all efforts were made to have equal gender representation among the youth, one female and three males took part. The youth held various positions in the youth departments in their local parishes. Two were youth secretaries, of whom one was a female; whilst one was a treasurer, and the fourth was a chairperson. The female and one male had secondary education, while the other two males had primary education.

The last group in this category was orphans, consisting of two males and two females. The age group of the orphans and youth were between 15 and 29, which shows that they were old enough to give relevant information about the pandemic, since it was present in the midst of their families and communities. All of the four orphans who took part in the study were at different levels of secondary education from form one to four.

3.4 In-depth interviews

This study adopted a qualitative approach using in-depth interviews that consisted of open-ended questions. Open-ended questions were relevant in this study because they:

leave the participants completely free to express their answers as they wish, as detailed and complex, as long or as short as they feel is appropriate. No restrictions, guide-lines, or suggestions for solutions are given.[160]

The individual in-depth interview method was used for all forty-nine participants who took part in the study from January to March 2007 and January to February 2008 respectively. Catherine Marshall and Gretchen Rossman describe an in-depth interview as "a conversation with a purpose."[161] This is in line with Denis who contends that: "an interview is a conversation which aims at the exchanging of information, and it is also a relationship."[162] The interview method is thus a dialogue between a researcher(s) and an interviewee(s) for the purpose of gathering or exchanging information. The dialogue between the respondents and myself was a learning process for both parties and it generated valuable information for the current study. I agree with Denis that the interview is also a relationship because without that relationship, conversation cannot occur. Prior to the interviews, I had to initiate a relationship with the respondents to open the door for the actual interviews.

Guiding open ended questions were prepared for each category of people (see appendices 1- 4). The reason I designed my own questions is because there is little existing research of this kind in Kilimanjaro. The broad categories of the interview included the following. First, the biographical information such as the gender, age, education, position held/not held in the church and the name of circuit/institution to which the participants belonged was established. This section was common to all participants since it was crucial for the study to specify the category of people who took part in the research due to the fact that HIV and AIDS affects the whole human race with no respect of age, sex, education, ethnic group or nationality.

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[160] Claire Bless and Craig H. Smith, *Fundamentals of Social Research Methods: An African Perspective*, 2nd edition, Kenwyn: Juta & Co. Ltd, 1995, p. 120.
[161] Catherine Marshall and Gretchen Rossman, *Designing Qualitative Research*, 3rd edition, London: SAGE Publications, 1999, p. 108.
[162] Philippe Denis, "Introduction," in Philippe Denis (ed), *Orality, Memory & the Past: Listening to the Voices of Black Clergy under Colonialism and Apartheid*, Pietermaritzburg: Cluster Publications, 2000, p. 3.

Second, questions about participants' understanding of issues around the HIV and AIDS pandemic were posed to the entire sample. Their knowledge with regard to the pandemic, such as the factors that reinforce the spread of HIV within communities, was valuable for this study.

Third, questions about the diocese's HIV and AIDS policy and the theology of HIV and AIDS were posed to policy makers who are the key people with regard to the well-being of the church members. At the time of the interviews however, the HIV and AIDS policy had not yet been released for implementation, and therefore questions falling under this section were not answered.

Fourth, questions concerning the diocese's HIV and AIDS programmes, gender sensitivity and stigma related to HIV and AIDS were directed to primary health education coordinators, zonal educators and congregants. However, under the section on HIV and AIDS programmes there were some questions which were aimed at the coordinators and zonal educators only, while others were aimed at congregants only, since the first two categories are implementers of the programmes, whereas the latter are the recipients of their services. This oral interview method gave me the opportunity to interact with people more closely and hence helped me to understand their feelings, concerns and how they think and react to the pandemic, particularly with regard to gender.

Permission was sought from the diocese authorities to conduct interviews within the diocese, and this was granted (see appendices 5, 6 and 7). As outlined above, I interviewed three categories of people. These were the policy makers, implementers of the ELCT Northern Diocese HIV and AIDS programmes and congregants.

In the category of policy makers I met with the deans (heads of circuits) at the diocese headquarters on different days and discussed with them the nature of my research since they had already received the letter concerning the study from the diocese. They were all willing to be interviewed, and also provided the names of other individuals whom it

would be important to interview to increase the validity of my study. At the same time, I requested from each dean a female representative from the decision-making level of the Executive Council to ensure gender balance, since each circuit was to be represented by two members. All the circuits supplied the name of a woman except one, which had only males on the diocese Executive Council as mentioned above. The deans gave me their own contact details as well as those of their representatives. Hence, it can be seen from this interaction and from the ways in which I came into contact with all the participants in my research, how important the snowballing technique was to my study. This is a most appropriate method for purposeful sampling in the context of African societies which are communal. As a minister in this diocese, it was not difficult for me to gain access to the community for this study.

This first encounter was successful because all consented to be interviewed. I met with the participants in this category at venues and times which were convenient to them. Between January and February/March 2007, I interviewed all the policy makers, diocese/circuit coordinators and zonal educators and congregants from two circuits. I also consulted various diocese and circuit minutes and documents that were relevant to my work. The second lot of the interviews took place in January and February 2008 when I dealt with the other two circuits included in this study.

In the category of the implementers, the diocese public health education coordinator (PHEP) was the most important person to connect me to the circuit coordinators. After explaining to her about the aims of and requirements for my study, she informed me about a business meeting for all PHEP coordinators, which was to take place on 9 January 2007. She gave me the opportunity to explain to the circuit coordinators at this meeting the nature of the study, and to inform them of the sample of people to be included in the research. They indicated their willingness to be interviewed, and so I gave them their consent forms. Again the snowballing technique was helpful because these circuit coordinators in turn put me in contact with the rest of the respondents – the zonal educators[163] and parishes to be studied. All the meetings with this category of

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[163] Each circuit coordinator was requested to select four active zonal educators – females and males.

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participants took place at the central office of the circuit PHEP unit (circuit office) or at the location the circuit coordinator is stationed (Machame and Marangu Hospitals).

In the category of the congregants, it was the parish pastors who put me in contact with the congregants who became participants in the study. We met at the parish centres prior to the interviews in order to establish trust and for me to inform them of the purpose of the research. Fortunately all were looking forward to participating in the study. All the interviews of the congregants took place at the parish premises.

All the interviews were conducted in Swahili, which is the national and common language spoken by the majority of Tanzanians including the studied population. An assurance of confidentiality and anonymity was given, explaining to the respondents that their names would not be transcribed in the written document. This was clearly stated in their consent form, which each participant signed and returned to me (see Appendix 8). The interviews were recorded using a tape recorder and at the same time I took notes. The data was then transcribed and translated into English by myself.

It is also important to note that I made use of an informal triangulation research method in that besides the official 49 participants, I also had face-to-face discussions with other individuals who had relevant information for the study.

Furthermore, in addition to the oral interviews, the minutes of the diocese and other reports were consulted: specifically the diocese HIV and AIDS draft policy, diocese/circuits' PHEP letters and annual reports. In addition, the reports of orphan ministry carried out by HUYAMWI, Moshi Pasua and Fuka Parishes were also studied. Participant observation as well as case studies were also sources of information. Apart from the primary sources, documentation from the library and other sources were used. These included books, journals, theses, magazines, newspaper articles and internet materials.

3.5 Participant observation

Participant observation is a research method whereby the researcher takes part in the activities of the people or group or situation that is being studied.[164] In some cases, the researcher may have been a member of the studied community or people prior to the research.[165] I agree with Monette, Sullivan and DeJong regarding the nature and criterion that determine a researcher as a participant observer. In view of this, my observation was mainly related to the parish experience during my pastoral ministry as described in chapters one and six. For instance, my motivation to carry out this study stems from the challenges raised by HIV and AIDS that I observed in a particular parish – which is not among the parishes examined in this study during my ministry as a pastor. This particular parish was also the setting for the case studies that are incorporated in this study.

3.6 Case studies

Case studies can be about "individual people, individual people in a social context, family relations or groups."[166] The purpose of the case study is description.[167] The case studies that are incorporated in chapter six focus on individual persons in the course of their illnesses. Their narrative stories during the researcher's pastoral ministry were related to Luther's advice on how an individual needs to prepare their soul before death.

3.7 Limitations

One limitation of the study was related to the unavailability of the HIV and AIDS policy of the diocese. Since the policy was not yet in place, questions that fell under the policy section were not addressed as intended, cutting short the interviews with the policy makers. However, two of the respondents in this category were aware that the diocese was in the process of formulating an HIV and AIDS policy because they are among the staff members at the head office of the diocese. I managed to secure a copy of the draft policy document from the secretary of the Diaconal Department who was one of the

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[164] Duane R. Monette, Thomas J. Sullivan and Cornell R. DeJong, *Applied Social Research: Tool for the Human Service*, 2nd edition, Philadelphia: Holt, Rinehort & Winston, 1990, p. 233.
[165] Monette, Sullivan and DeJong, *Applied Social Research*, p. 233.
[166] Martin Brett Davies, *Doing a Successful Research Project: Using Qualitative or Quantitative Methods*, Hampshire: Palgrave Macmillan, 2007, p. 184.
[167] Beverly R. Dixon, Gary D. Bouma and G. B. Atkinson, *Handbook of Social Science Research*, Oxford: Oxford University Press, 1987, p. 107.

committee members responsible for the drafting the policy. The HIV and AIDS draft policy reflects the current HIV and AIDS programmes of the diocese with minor advances in some of the programmes, in particular physical and medical care. This information will be incorporated in chapter five to avoid duplication (see the diocesan HIV and AIDS draft policy in appendix 13).

3.8 Confidentiality

In order to ensure confidentiality, the following chapters, which deal with the findings of my research, make use of abbreviations to represent each category of the participants as well as for each individual participant within that category. For the policy makers, who numbered eleven, they were named as PM-1 to PM-11. To represent the five coordinators, CD-1 to CD-5 was used. Meanwhile for the zonal educators who were fourteen in number, the abbreviations ZE-1 to ZE-14 were employed. To indicate the congregants who ranged from people living with HIV and AIDS, to older people, youth and orphans, codes were also used. People living with HIV and AIDS acquired the abbreviation of PLWHA-1 to PLWHA-7 as they were seven in number; whilst older people were abbreviated as OP-1 to OP-4 as there were four of them. The name youth was used in full for this category but they were titled as Youth-1 to Youth-4. Lastly, orphans were abbreviated as ORP-1 to ORP-4.

3.9 Conclusion

Given that the theories which inform my analysis and the content which I am focusing on are gendered, I have aimed to develop a methodology of research that is congruent with gender sensitivity. Firstly my choice of open-ended questions rather than questionnaires gave the participants the opportunity to share deeply from their experiences rather than simply ticking boxes. Secondly, when choosing my research sample I tried to ensure a gender balance, though this was not always possible especially with regard to the leadership in the diocese which is not gender inclusive. Nevertheless even the absence of women in leadership speaks to my research. Thirdly, besides aiming to be gender sensitive in my method itself, the nature of the content of my questions also raised gender awareness among the participants. This again is important to feminist research, because it

always seeks to transform society. Having described the methodology of my research, I now move on to the first objective of my study in the next chapter. The objective of the next chapter is thus to describe the context of HIV and AIDS in Tanzania in order to understand the overall context in which the HIV and AIDS programmes of the church are developed and implemented.

CHAPTER FOUR

SKETCHING THE CONTEXT OF HIV AND AIDS IN TANZANIA

4.1 Introduction

Having examined the research methodology governing the study in the previous chapter, this chapter will explore the context of the study. This will include the profile of Tanzania, the situation of HIV and AIDS in the country and the socio-economical and cultural factors that contribute to the transmission of HIV such as poverty, migrant labour and female genital mutilation (FGM), early marriage and polygamy. Thereafter, the national governmental response to the pandemic will also be examined in order to assess the effectiveness of this response in practice. Furthermore, the HIV and AIDS programmes of the government are explored in detail so that in later chapters the programmes of the church can be evaluated against those of the government. Each of these programmes will be examined both historically and in their current manifestation in order to demonstrate the grave threat that each of the factors contribute to the spread of HIV. The objective of this chapter is to highlight the situation of HIV and AIDS in Tanzania in order to establish the need for a response from the church and to assess - in subsequent chapters - given the factors contributing to the pandemic, whether or not the church's response is adequate.

4.2 Profile of Tanzania

Tanzania is situated south of the equator in East Africa. It covers an area of 945, 000 sq km, (365,000 sq miles), bordering Uganda and Kenya in the north, Rwanda, Burundi, and DRC in the West, Zambia, Malawi and Mozambique in the south, and the Indian Ocean to the east.[168] The country is also surrounded by three great lakes: Victoria in the north, Tanganyika in the west and Nyasa in the south. The country population according to the 2002 census stood at 34.6 million,[169] and July 2010 estimates had risen to 41.9 million.[170]

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[168] Country Profile: "Tanzania," <http://www.fco.gov.uk/servlet/front?pagename=openMaker/xcelerate/showpage&c=page&cid=10070293 94365&a=kCountryprofile&aid=1019745099478>Accessed: 05/03/2007, p. 1.
[169] 2002 Population and Housing Census- General Report, "2002 Regional Census results," p. 1.
[170] Index Mundi, "Tanzania Population," <http://www.indexmundi.com/tanzania/population.html> Accessed: 10/11/2010, p. 1.

There are more than 130 ethnic groups in Tanzania.[171] The Sukuma, Chagga, Nyamwezi, Zaramo and the Makonde outnumber the other groups.[172] Swahili is the official language, spoken by most of the Tanzanian population. English is the medium of instruction in all secondary schools and higher learning institutions. The religions include Christianity 45%, Islam 35% and traditional belief accounting for 20% on the Tanzanian mainland, whereas in Zanzibar 99% of the population is Muslim.[173]

4.3 Current situation of HIV and AIDS in Tanzania

Tanzania is one of the hardest hit countries with regard to HIV and AIDS in sub-Saharan Africa. Its first three AIDS cases were reported in 1983 in the Kagera region in the North West of the country.[174] By 1986 all mainland regions in Tanzania had reported HIV and AIDS cases, after the establishment of the National Task Force, which later became the National AIDS Control Programme (NACP) in 1988.[175] For example, there were a cumulative total of 25 503, 81 498, 109 863 and about 600 000 cases respectively reported in the years 1990, 1995, 1998,[176] and 1999.[177] By the end of 2009, it was estimated that 1 400 000 Tanzanians were infected with the virus, of which 760 000 were women aged 15 and above, while 140 000 were children under 15 years.[178] The estimated death rate was 96 000, while 970 000 children had lost one or both parents due to HIV and AIDS related illnesses.

Accessed: 15/02/2010, p. 1.

[171] Index Mundi, "Tanzania Ethnic Groups," <http://www.indexmundi.com/tanzania/ethnic_groups.html> Accessed: 20/04/2010, p.1.

[172] EISA, "Tanzania: Fact file," <http://www.eisa.org.za/WEP/tan7.htm> Accessed: 11/02/2010, p. 2.

[173] Eisa, "Tanzania: Fact file," p. 2.

[174] Setel, "Local Histories of Sexually Transmitted Diseases and AIDS in Western and Northern Tanzania," p. 119. See also Bujra and Baylies, "Responses to AIDS pandemic in Tanzania and Zambia," p. 27, Juma, *Coping with HIV/AIDS in Education,* p. 2.

[175] Setel, "Local Histories of Sexually Transmitted Disease and AIDS in Western and Northern Tanzania," p. 121. See also Bujra and Baylies, "Responses to AIDS pandemic in Tanzania and Zambia," p. 32.

[176] Bujra and Baylies, "Responses to AIDS pandemic in Tanzania and Zambia," p. 27.

[177] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 7. See also Tanzania National Website, "HIV/AIDS in Tanzania," <http://www.tanzania.go.tz/hiv_aids.hmtl> Accessed: 05/04/2007, p. 1.

[178] UNAIDS, "United Republic of Tanzania," <http://www.unaids.org/en/CountryResponses/Countries/united_republic_of_tanzania.a...>Accessed: 20/07/2010, p. 1.

4.4 Modes of HIV transmission in Tanzania

The National Policy on HIV and AIDS in Tanzania declares that the dominant mode of HIV transmission is heterosexual intercourse accounting for about 90 percent of all infections.[179] This became evident because over 10 percent of women visiting antenatal clinics in some rural areas were diagnosed HIV-positive in 1997.[180] The same means of transmission is the most common in many African countries accounting for about 87 percent.[181] However this contrasts with Europe and the USA where homosexual intercourse and intravenous drug use are the main routes of HIV infections.[182] HIV infection was and remains prevalent along the highways[183] and in urban centres, later spreading to the rural communities.[184]

The Tanzania Commission for AIDS (TACAIDS) report indicates that women, youth, the poor and mobile groups are among the population sectors which are most affected by the pandemic.[185] The report further states that the vulnerability to the pandemic of women and youth is associated with early marriages and teenage girls having sexual relations with older men (intergenerational sex). Economic hardships, oppressive customary laws, beliefs, and polygamy were noted as barriers to women's ability to protect themselves from HIV infection.[186] The report also asserts that women are in the category of the poor due to their lower levels of education, unemployment and denial to property ownership. The mobile population groups include migrant workers, petty traders, commercial sex

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[179] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 7. This mode of HIV infection has recently fallen to 80 percent. Avert, "HIV and AIDS in Tanzania," <http://www.avert.org.hiv-aids-tanzania.htm> Accessed: 10/11/2010, p. 1.

[180] Tanzania National Website, "HIV/AIDS in Tanzania," p. 3.

[181] Sonja Weinreich and Christoph Benn, *AIDS - Meeting the Challenge- Data, Facts, Background,* Geneva: WCC Publications, 2004, p. 3, 4. See also Peter Piot and Michael Bartos, "The Epidemiology of HIV/AIDS," in Max Essex et al. (eds), *AIDS in Africa*, 2nd edition, New York: Kluwer Academic, 2002, p. 202.

[182] Nana Poku, *AIDS in Africa: How the Poor are Dying,* Cambridge: Polity Press, 2005, p. 53.

[183] USAIDS, "Long Distance Truck Driving and Potential for High Risk Behaviour: Findings from a dipstick study of truck drivers at Chalinze, Mikumi and Makambako Truck Stops August 2009," <http://pdf.usaid.gov/pdf/docs/PNADR301.pdf> Accessed: 15/02/2010, p. 1 Chalinze (Pwani region), Mikumi (Morogoro region) and Makambako (Iringa region) are three main truck stops, which are located along the southern transport routes that connect Dar-es-Salaam to the neighbouring countries of Zambia and Malawi. Due to long distances travelled and delays at border crossings, truck drivers spend their nights in some of these truck stops where they usually have casual sex with sex workers.

[184] Tanzania National Website, "HIV/AIDS in Tanzania," p. 2.

[185] Tanzania National Website, "HIV/AIDS in Tanzania," p. 4

[186] Tanzania National Website, "HIV/AIDS in Tanzania," p. 4

workers, military personnel, and long distance truck drivers, all of whom are also vulnerable to HIV infection. It is true that the poor have high rates of infection but the same goes for wealthy individuals due to the fact that the poor exchange sex for money from the well–to-do males. The survey conducted by the National Bureau of Statistics and Tanzania Commission for AIDS between 2003 and 2004 affirms HIV prevalence among well-off couples. It states that: "HIV prevalence increases with wealth. Infection rates are three times higher among those in the highest wealth quintile than those in the lowest quintile."[187] Since the wealthy have cash to pay for as many partners as they want and since they are most likely to do so without using preventive measures, their risk-taking behaviour endangers not only themselves and their clients but also their stable marital partners.

Mother-to-child transmission is another form of HIV infection in Tanzania, which occurs during pregnancy, childbirth and breastfeeding.[188] This accounted for about 4.6 percent of all reported cases in 2004.[189] The medical care service to prevent mother-to-child transmission (PMTCT) of HIV was introduced in the country during 2000.[190] The national guidelines for this service state that out of ten infants, two to three will be infected through the abovementioned routes.[191] Since breastfeeding is the best way to feed an infant, an HIV positive mother despite her status has the option to fully breast feed her baby for the first six months, and hence needs greater support from the family and community to enable her to fulfil this crucial responsibility.[192] The PMTCT services

[187] TACAIDS, "Key Findings from the 2003-04 Tanzania HIV/AIDS Indicators Survey (THIS)," <http://www.measuredhs.compdfs/TanzaniaHIVFactsheet.pdf> Accessed: 14/05/2008, p. 1. See also National Bureau of Statistics and TACAIDS, "2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)," <http://www.unaidsrestasa.org/files/UI/Tanzania-HIV-TB-Malaria-Survey.pdf> Accessed: 04/06/2010, p. 1
[188] The United Republic of Tanzania, *National Policy on HIV/AIDS,* p. 7.
[189] Kessy, Mallya and Mashindano, "Tanzania," p. 216.
[190] UNICEF, "2002 TNZ: Evaluation of the UNICEF-sponsored Prevention of Mother-to-Child Transmission (PMTCT) Pilot Project in Tanzania," <http://www.unicef.org/evaldatabase/index_311132.html> Accessed: 19/05/2009, p. 1.
[191] Ministry of Health, "Guidelines for Prevention of Mother-to-Child Transmission (PMTCT) in Tanzania," <http://www.districthealthservice.com/cms/upload/policycat-54-9100.pdf> Accessed: 08/07/2010, p. 38.
[192] Ministry of Health, "Guidelines for Prevention of Mother…." p. 41

cover about 78 percent of the country to date.[193] The two Diocesan health institutions within the study area are part of this national coverage, as will be discussed later in this study. The fact that infants are protected from HIV infection through preventative drug treatment makes it crucial for the government to ensure that the PMTCT is available throughout the country, and that all pregnant women can access this service because it promotes and sustains life.

Lastly, contaminated blood transfusion[194] is another route of HIV transmission, which accounted for 0.5% of infection.[195] To ensure that health facilities obtain safe blood, the government has established eight Zonal Blood Banks between 2006 and 2008 that are responsible for the collecting and screening of donated blood and for distributing it into their health institutions located in their zones.[196]

4.5 Determinants of the pandemic in Tanzania

The major determinants of the HIV and AIDS pandemic in Tanzania are: socio-economical, cultural, and biological. These are similar to the factors that are found in many parts of Africa.

4.5.1 Socio-economical determinants

Tanzania is among the poorest countries in Africa. The TACAIDS report indicates that about 50 percent of the country's population lives below the poverty line, and that women are harder hit than men.[197] There are numerous socio-economic factors that fuel the transmission of HIV as will be discussed below.

4.5.1.1 Poverty

The national economic crisis of the late 1970s, which was caused by the high cost of the war between Tanzania and Uganda (1978), the high oil price and severe famine across

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[193] UNAIDS, "United Republic of Tanzania – UNGASS 2010 Progress reporting," <http://data.unaids.org/pub/Report/2010/Tanzania_2010_progress >Accessed: 10/11/2010, p. 1.
[194] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 7.
[195] Kessy, Mallya and Mashindano, "Tanzania," p. 216.
[196] WHO, "World Blood Donor Day Report – United Republic of Tanzania," <http://www.who.int/countries/tza/annual_events/wbd09/enindex.html> Accessed: 09/06/2010, p. 1, 2.
[197] Tanzania National Website, "HIV/AIDS in Tanzania," p. 4.

the nation,[198] forced the country to revisit its policies, and to thus adopt the Structural Adjustment Programmes (SAPs) as dictated by the loan agreements with the World Bank, in the late 1980s. Although there were some positive consequences that resulted from this policy, such as the lowering of inflation, reduction of government expenditure, and the increase of production, it also worsened economic disparity and social problems which affected women more negatively than men.[199] For instance, women were the first to be retrenched from their jobs because they were less skilled; the majority were employed in service-oriented jobs whose budget was drastically cut.[200] The retrenchment of men, which was also a reality, placed an additional a heavy burden on women who had to seek for other means to support their families. The implementation of SAP programmes of the World Bank, on the one hand together with the patriarchal social customs and traditions, which exclude women from accessing and owning resources and credit on the other hand, have both contributed to impoverish women in Tanzania.

Poverty is the major social determinant in determining the quality of life of people; hence it forced women to employ various means to earn their living and those of their dependants. The majority of women are unemployed and most of them are found in the rural areas, involved in agriculture on a small scale or with petty trades.[201] A few who have jobs are employed in unskilled jobs due to their low level of education as stated above.

The inability of women and children to have control over family resources, and how to use them, due to the gender constructions in favour of men, have been noted as a factor that leads them to poverty.[202] The Household Budget Survey conducted in Tanzania in 2000 and 2001 to measure the levels of poverty found that:

[198] Frances Vavrus, *Desire and Decline: Schooling Amid Crisis in Tanzania*, New York: Peter Lang, 2003, p. 56.
[199] Fenella Mukangara and Bertha Koda, *Beyond* Inequalities: *Women in Tanzania*, Dar-es-Salaam: TGNP/SARDC, 1997, p. 20, 21.
[200] Mukangara and Koda, *Beyond Inequalities*, p. 21.
[201] Mukangara and Koda, *Beyond Inequalities,* p. 25, 27.
[202] Mukangara and Koda, *Beyond Inequalities*, p. 22.

- More than a third of the population was living below the basic needs poverty line and nearly a fifth was living below the food poverty line according to the standards set by the National Bureau of Statistics.
- Female-headed households[203] constituted 19% of the poorest households. The Participatory Poverty Assessment carried out during the same period found that households headed by widows were among the most vulnerable.
- Poverty seems to be increasing: there were nearly 2 million more Tanzanians below the basic poverty line in 2000/01 than in 1992/93 due to the growth of the population which swelled the numbers at the lower levels of the socio-economic scale.[204]

The survey shows that a large proportion of the population is living in abject poverty in that they lack their basic needs including food; and that the most affected households are those headed by women, especially widows. It also reveals that the poverty situation is increasing basically because the factors that reinforce poverty have not been addressed, such as unemployment (especially among young population) and the marginalisation of women in society.

For the sake of their survival and that of their children, some women, such as those who are employed but earn minimal wages, and the unemployed, have resorted to sex work,[205] a situation that puts them and their clients at risk of contracting HIV. Although sex work involves both a man and a woman, it is only the woman who is considered as a prostitute. Sex work is unlawful in Tanzania although individuals are actively at work in this field.[206] For this reason, data on sex workers are not accessible, though the available oral information affirms an increase in prostitution resulting from poverty and the commercialisation of goods and services.[207] Women activists confirm the existence of locations known to host prostitutes, and that the police have regularly harassed female sexual workers exclusively, as if males, as the customers are not playing a role in this

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[203] Female-headed households (FHH) are said to be headed by a single unmarried women, or by women who were once married but are divorced, separated or widowed. FHH can also be headed by women in co-habitation arrangements where a man and woman live together in most cases without official marriage.
[204] Ophelia Mascarenhas, *Gender Profile of Tanzania: Enhancing Gender Equity*, Dar-es-Salaam: TGNP, 2007, p. 36.
[205] Mukangara and Koda, Beyond Inequalities, p. 30.
[206] Mukangara and Koda, *Beyond Inequalities*, p. 30.
[207] Mukangara and Koda, *Beyond Inequalities,* p. 30.

industry at all.[208] This gender-biased strategy (based on stereotypes) has failed to eliminate the practice because male counterparts who pay cash for the sex are not held accountable by the law. According to Rao Gupta, this approach falls under the programmes that focus on stereotypes of women and men. In this context, it is only women who are regarded as vectors of the transmission of HIV; hence this leaves a loop hole for men to continue with their risk taking behaviour which is detrimental to all those involved in their sexual networking. This stereotype-based strategy of harassing women involved in sex work has also been noted in other countries.[209]

The TACAIDS report states that commercial sex workers are among the categories of people who increase rate of the sexual transmission of HIV infection.[210] The report further indicates that studies conducted by the African Medical and Research Foundation (AMREF) along the major truck stops and towns revealed that sex workers have a high HIV prevalence rate of up to 60 percent. Another study carried out by Mradi wa UKIMWI Tanzania na Norway (MUTAN) in Moshi municipality, illustrates that bar workers have an HIV infection rate of 32 percent, while the study in Dar-es-Salaam of the same category of people indicates that 50 percent of them are HIV positive.[211] It has been noted that workers in the drinks and beverages sectors are low paid, a situation which encourages them to engage in prostitution to supplement their income.[212] Sheeren Usdin has this to say about the way poverty fuels HIV, "Being poor reduces people's options in life. For example, faced with the prospect of starvation now or illness later, millions of people (women in particular) are forced into sex work to keep their families alive."[213] Poverty forces women to risk their lives to ensure that they can provide for their families or dependants, a situation which is fuelled by the gender roles assigned to them as providers.

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[208] Mukangara and Koda, *Beyond Inequalities*, p. 31.
[209] Ayanga, "Religio-Cultural Challenges in Women's Fight against HIV/AIDS in Africa," in T. M. Hinga at el. (eds), *Women, Religion and HIV/AIDS in Africa: Responding to Ethical and Theological Challenges*, Pietermaritzburg: Cluster Publications, 2008, p. 40 notes similar harassment among female sexual workers in Kenya. She therefore argues that this harassment prevents these women from seeking early treatment for sexually transmitted diseases, which poses a threat to their health, for fear of being arrested.
[210] Tanzania National Website, "HIV/AIDS in Tanzania," p. 4.
[211] Tanzania National Website, "HIV/AIDS in Tanzania," p. 4.
[212] Mukangara and Koda, *Beyond Inequalities*, p. 30.
[213] Usdin, *The No-Nonsense Guide to HIV/AIDS,* p. 36.

To redress this problem, gender sensitive and empowerment programmes that will enable women to be economically self-supporting, are critical at all levels of society, as suggested by Rao Gupta in the second chapter. Enhancing the ability of women to engage in income generating activities and giving them the right to own property, are a way forward for them to have autonomy over their lives, which can serve as a strategy to alleviate poverty and to minimize risky behaviour too. Migrant labour, which is linked to poverty, is another social factor which fuels the spread of HIV.

4.5.1.2 Migrant labour

Poverty or low income in households has encouraged labour migration.[214] As discussed previously, a significant section of the population has migrated from rural settings to towns and cities to search for employment and this is a pattern which is uniform across the country. The majority of migrants are men, leaving behind their families and only visiting them occasionally. The TACAIDS report is silent on the sexual behaviour of the migrant men while they are living in towns or cities; instead it assumes that the women who are left behind may easily engage in extramarital relations. It states:

> Low and irregular income creates an environment that encourages labour migration. Women in such situations may be easily tempted to exchange sex for money and this puts them and their spouses at risk for HIV.[215]

It is not surprising that a woman in a desperate situation might be forced to sell her body in order to feed her family especially if the man (husband) who left his family does not provide maintenance, which is the reality of many. It is amazing that men who exchange money for sex are not viewed as dangerous to their marital partners in that it is only seen to be women who are at risk of infecting their husbands. This report, which I regard as a male perspective of the situation, overlooked the male risk-taking behaviour, which is potentially the main cause of the spread of HIV among married people; instead it casts

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[214] Tanzania National Website, "HIV/AIDS in Tanzania," p. 4
[215] Tanzania National Website, "HIV/AIDS in Tanzania," p. 4.

blame on women, a situation which continues to reinforce the transmission of HIV. Conversely to the TACAIDS report, Ronald Nicolson argues that:

> Male migrant workers leave sexual partners in the countryside, to whom they have at least some degree of responsibility, and take multiple casual partners in the city to whom they have none. The women remaining in the rural areas are dependent on the men to provide them with support, so are in no position to negotiate for safe sex when their husbands return on occasional visits.[216]

This observation affirms the vulnerability of women who are not in a position to insist on safer sex with their husbands due to their low status in society and their economic dependence on men. For instance, studies in Tanzania reveal that married individuals have higher rates of HIV infection (18%) than other categories of people.[217] The gender disparity prevents women from protecting themselves from HIV when their husbands make sexual advances toward them. Unless Tanzania accepts a change in the sexual behaviour of both men and women, HIV and AIDS will continue to ravage the nation. In the following chapters, I will assess the degree to which the church's HIV and AIDS programmes have been successful in addressing the gender imbalance between men and women with regard to sexual relationships. It is only through gender sensitive programmes that this problem can be resolved, as explored in chapter two. In the next section, I will explore the cultural factors that facilitate the transmission of HIV in Tanzania.

4.5.2 Socio-cultural determinants

In Africa in general, culture plays a vital role in the life of each member of the society.[218] Some socio-cultural practices and beliefs enhance the life of their members, but others discriminate against or exploit individuals and put them, especially women, in danger of HIV infection. Some of the cultures may have been compatible with social realities in the

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[216] Ronald Nicolson, *God in AIDS?* London: SCM Press, 1996, p. 226.
[217] Kessy, Mallya and Mashindano, "Tanzania," p. 216.
[218] Musimbi Kanyoro, "Culture," in Virginia Fabella and R.S. Sugirtharajah (eds), *Dictionary of Third World Theologies*, Maryknoll: Orbis Book, 2000, p. 62. See also Hannah Kinoti, "Culture," in Letty Russell and J. Shannon Clarkson (eds), *Dictionary of Feminist Theologies*, Kentucky: Westminister John Knox Press, 1996, p. 63. Ayanga, "Religio-Cultural Challenges in Women's Fight against HIV/AIDS in Africa," p. 36.

past but with the advent of HIV they have become destructive, and thus need to be challenged and discarded. Female genital mutilation, early marriage, polygamy, wife inheritance, obligatory marital sex, and the encouragement of multiple sexual partners for men are some of the cultural practices that subjugate women to HIV infection in Tanzania.[219]

4.5.2.1 Female genital mutilation or female circumcision

Female genital mutilation (FGM) or female circumcision is a gendered cultural practice that has been passed on from one generation to another. In Tanzania, 18% of women are said to have undergone the practice although it is banned by Tanzanian law.[220] Two Demographic Health Surveys conducted in 1996 and 2004-05 found a prevalence of FGM in the following regions: Arusha and Manyara[221] (81%) of women),[222] Dodoma (68%), Mara (44%), Kilimanjaro (37%), Iringa (27%), Tanga and Singida (25%) and Morogoro (20%).[223] The 2006 National Population Policy report distributes the age at which FGM is practised as follows:

> The percentage of girl-children circumcised by age 1 is higher in urban areas (34 percent) than in rural areas (28 percent), and the corresponding proportion of circumcisions at age 13 or later is (19 and 31 percent), respectively. About 9 percent of FGM takes place at the ages of 19 and 31 years, 14 percent at the age of 30-39 years, 19 percent at the age of 40-44 years and 23 percent at the age of 45-49 years.[224]

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[219] Tanzania National Website, "HIV/AIDS in Tanzania," p. 5. Irin News, "East Africa: Feature-Traditional culture spreading HIV/AIDS," <file://F://Traditional_culture_spreading_HIV-AIDS.htm> Accessed: 28/03/2007, p. 2.

[220]Mascarenhas, *Gender Profile of Tanzania,* p. 56. See also Mamtora and Musendo, "Tanzania: Abolish Genital Mutilation," <http://womensnet.org.za/oldnews99/tanzmut.htm> Accessed: 05/05/2007 p.1. Leonard Mwakalebela, "Female genital mutilation declines," <http://www.dailynews.co.tz/home/?n=7290&cat=home> Accessed: 16/07/2010, p. 1.

[221] Manyara region split from Arusha region and became a new region in 2005. Therefore, the FGM figure does not cover these regions separately. Both regions are dominated by the Maasai ethnic group who practice FGM strictly.

[222] Leonard Mwakalebela, "Female genital mutilation declines," <http://www.dailynews.co.tz/home/?n=7290&cat=home> Accessed: 16/07/2010, p. 1.

[223] Mamtora and Musendo, "Tanzania: Abolish Genital Mutilation," p.1. See also Peasgood at el. (eds), *Gender and Primary Schooling in Tanzania*, Brighton: Institute of Development Studies, 1997, p. 51. See also Unicef, "Tanzania: FGM/C Country Profile," <www.childinfo.org/files/Tanzania_FGC_profile_English.pdf> Accessed: 29/01/2010, p. 1.

[224] UNHCR, "Tanzania: The practice of female genital mutilation (FGM); state protection available," <http://www.unhcr.org/refworld/country,,IRBC,,TZA,446d621e2,48d2237c28,0.html>Accessed: 30/06/2010, p. 2.

The 2008 report released by the Legal and Human Rights centre (LHRC) [225] states that globally Tanzania has the fifth highest prevalence of FGM.[226] The report also notes that about 20 of the 130 ethnic groups in Tanzania practice FGM, and that this practice varies according to region. The permanent secretary for the Ministry of Community Development, Gender and Children, Mariam Mwaffosi who was addressing the FGM Zero Tolerance Day held at national level in Dodoma on 6 February 2010, indicated that the FGM rate has declined from a prevalence rate of 18 to 15 percent over the last ten years.[227] This decline involves regions of Mara where the practice declined from 44 to 38 percent, Kilimanjaro, where it fell from 37 to 25.4 percent, Morogoro where FGM was reduced from 20 to 18 percent and Iringa where its prevalence came down from 27 to 22.7 percent.[228] However, the FGM rate in Singida region had increased from 25.4 to 43 percent. In view of this, the permanent secretary admitted that the ministry is aware of the limitations of the Penal Code Act, which it meant to punish the violations of the law in this regard. This Act will thus be reviewed.[229] She further maintained that the ministry had a strategic plan (covering the period 2001-2015) in place to eradicate this harmful practice.

Agness Shekifu states that *Sunna* and clitoridectomy are the two forms of mutilation that are practiced in Tanzania.[230] Meanwhile, the Centre for Reproductive Rights report mentions three forms of FGM. The third category is infibulation or the Pharaonic operation, which is performed mainly by the Somali ethnic group[231] residing in Arusha region.[232] The report notes that some ethnic groups in Iringa and Morogoro regions practice *Sunna*; while the Chagga in Kilimanjaro perform the clitoridectomy. Anika Rahman and Nahid Toubia describe *Sunna* as involving the removal of the foreskin of the

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[225] LHRC is a non-governmental organization (NGO) that works to create public awareness of rights issues and provides legal aid services in Tanzania.

[226] UNHCR, "Tanzania: The Practice of female genital mutilation (FGM)," p. 2.

[227] Mwakalebela, "Female genital mutilation declines," p. 1.

[228] Mwakalebela, "Female genital mutilation declines," p. 1.

[229] Mwakalebela, "Female genital mutilation declines," p. 1.

[230] Agness Shekifu, "Is the Cultural Practice of Female Genital Mutilation (FGM) Compatible with Human Rights in Africa?" unpublished Masters thesis, University of Durban - Westville, 2002, p. 45. See also UNHCR, "Tanzania: The Practice of female genital mutilation," p. 1.

[231] The Somali ethnic group are migrants from Somalia who are predominantly Muslim.

[232] Center for Reproductive Rights, "Women's Reproductive Rights in Tanzania," <http://www.reproductiverights.org/pdf/SRTanzania98en.pdf> Accessed: 29/05/2007, p. 9.

clitoris, whilst, in the clitoridectomy the entire clitoris is removed, and infibulation involves the cutting of the total organ and stitching to narrow the cervix. [233]

Culturally, female genital mutilation was a significant rite of passage which a girl, after attaining puberty, was required to undergo, as it marked the transition from childhood to adulthood.[234] In traditional Chagga society girls and boys were obliged to undertake the ritual of circumcision. Aaron Urio asserts that: "the physical cutting took place very early in the morning after bathing in very cold water. Boys would undergo circumcision while girls underwent a clitoridectomy."[235] To shower in cold water before the cutting might have been regarded as a form of anaesthesia since such a service was not available.

The operation was done using knives or blades in the homes of the male and female circumcisers. The wound was treated with herbs to stop bleeding.[236] Since this rite was considered as a communal festival, family members, friends and neighbours joined together for the celebration at which singing and dancing were significant elements during the celebration.[237] After the wound had healed, the boys were taken away by a selected elderly man, who spent several months with them in a camp in the forest, and instructed them on family matters and community responsibilities.[238] Hunting and

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[233] Anika Rahman and Nahid Toubia, *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*, London: Zed Books, 2000, p. 7. See also Alice Walker and Patibha Parmar, *Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women*, London: Jonathan Cape, 1993, p. 377. Dorcas O. Akintunde, "Female Genital Mutilation: A Socio-Cultural Gang up Against Womanhood," in Mercy A. Oduyoye (ed), *Women in Religion and Culture: Essays in Honour of Constance* Buchanan, Ibadan: Seifer, 2007, p. 91.

[234] Otto Raum, *Chagga Childhood: A Description of Indigenous Education in an East African Tribe*, London: Oxford University Press, 1967, p. 304, 310. See also John Mbiti, *An Introduction to African Religion*, London: Heinemann, 1975, p. 91, 92. Mercy Oduyoye, "Women and Ritual in Africa," in Mercy Oduyoye and Musimbi Kanyoro (eds), *The Will to Arise: Women, Tradition, and the Church in Africa*, Pietermaritzburg: Cluster Publications, 2006, p. 12. Pacificah F. Okemwa, "Clitoridectomy Rituals and the Social Well-being of Women," in Musimbi Kanyoro and Nyambura Njoroge (eds), *Groaning in Faith: African Women in the Household of God*, Nairobi: Acton, 1996, p. 177. Rakoczy, *In Her Name: Women Doing Theology,* p. 281. Violet N. Kimani, "Human Sexuality: Meaning and Purpose in Selected Communities in Contemporary Kenya," in *The Ecumenical Review,* 56, 4, (October 2004), p. 411.

[235] Aaron Urio, *The Concept of Memory in the Chagga Life Cycle in Relation to Christian Eucharist Traditions*, Erlangen: Evangelical Lutheran Mission Publishing House, 1990, p. 58.

[236] Raum, *Chagga Childhood*, p. 307.

[237] Urio, *The Concept of Memory in the Chagga Life Cycle*, p. 58.

[238] Anza Lema, *The Foundation of the Lutheran Church in Kilimanjaro*, Hongkong: Minda Type Setting, 1982, p. 243.

enduring various hardships[239] were part of their instructions as they were regarded as family bread-winners and defenders. Anza Lema asserts that the circumcised girls were kept indoors for three months under the supervision of their grandmothers with a special diet and care, in order to enhance their beauty and attractiveness as prospective brides.[240] After this period, they were also given instruction, which prepared them to assume their future roles as wives and mothers. The teaching was offered by a mature and wise woman hired by their parents or the village. Knowledge and values concerning morals, procreation, birth spacing and pregnancy were offered to them as a group or as individuals.[241] The way their bodies work, and how to take care of their menses, hard work, and respect for and submission to their husbands, were also part of their teachings. After this intensive training a girl was eligible for marriage. This cultural practice is an indication that a girls' future was determined by marriage.

With the coming of Christian missionaries, female circumcision began to be discouraged in many societies in Africa due to its negative impact on women. Some governments also discouraged the practice and enacted laws to ban it, but the practice still prevails in many societies until today.[242] In the era of HIV and AIDS, female circumcision poses a threat because the tools used for the operation can be contaminated and hence transmit the virus from one person to another.[243] Surprisingly, missionaries or mission societies were divided on the practice of female circumcision.[244] The Leipzig Mission, which pioneered in Kilimanjaro, initially agreed to abolish female genital mutilation in their business

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[239] Chagga forum, "Chagga," < http://www.everyculture.com/wc?Tajikistan-to-Zimbabwe/Chagga.html> Accessed: 12/11/2007, p. 1.

[240] Lema, *The Foundation of the Lutheran Church in Kilimanjaro*, p. 244, See also Raum, *Chagga Childhood*, p. 307.

[241] Lema, *The Foundation of the Lutheran Church in Kilimanjaro*, p. 308.

[242] Mascarenhas, *Gender Profile of Tanzania*, p. 57. See also Mukangara and Koda, *Beyond Inequalities*, p. 57. UNHCR, "Tanzania: The practice of female genital mutilation," p. 1. Okemwa, "Clitoridectomy Rituals and the Social Well-being of Women," p. 175.

[243] Usdin, *The No-Nonsense Guide to HIV/AIDS*, p. 52.

[244] For instance, Church of Scotland Mission (CSM), which worked among the Kikuyu in Kenya strongly, condemned female genital mutilation (FGM), and those who opposed it were excommunicated. However, many of the indigenous people refused to abandon the practice which resulted in violence. The controversy of female circumcision caused the deterioration of the expansion of mission, hence paved way to the establishment of Independent Churches in Kenya in Klaus Fiedler, *Christianity in African Culture: Conservative German Protestant Missionaries in* Tanzania *1900 – 1940*, Leiden: E. J. Brill, 1996, p. 75, 76.

meetings but practically it was encouraged among the Chagga.[245] The agreement to eliminate the practice states:

> During the missionary conference of 1913 at Shighatini all had agreed unanimously that they should aim at abolishing circumcision by preaching, teaching and by discussing the issue with the congregations and their elders.[246]

The missionaries who worked among the Pare or Wapare (pl.), who reside in the eastern part of Kilimanjaro, implemented this agreement.[247] By 1917 congregations in Pare location, which included Shighatini, Vudee and Gonja, had accepted the need to do away with female genital mutilation.[248] The reluctance of the missionaries in Chagga area to raise the issue of mutilation was linked to the fear of losing congregants.[249]

However, when the indigenous people took over as church leaders from the German missionaries,[250] their first task, among others, was to abolish female circumcision among the Chagga.[251] The positive response in Pare congregations might have motivated the indigenous leaders to deal courageously with the matter. Thus, in 1922 Machame and Masama congregations in west Kilimanjaro agreed to abandon the practice as the Pare had.[252] However, the need to end circumcision in Old Moshi congregations was met with resistance, thus leaders employed disciplinary actions. Christians who continued to practice circumcision were excommunicated, denied Holy Communion and the names of those who underwent the operation were announced on Sundays.[253] Since this practice

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[245] Fiedler, *Christianity and African Culture*, p. 37.

[246] Fiedler, *Christianity and African Culture*, p. 82. See also Paul Fleish, *Lutheran Beginnings Around Mt. Kilimanjaro: The First 40 years*, Makumira Publications, 1998, p. 91.

[247] Pare or Wapare (pl) is a small ethnic group that resides in the eastern part of Kilimanjaro. The Pare area is mainly mountainous.

[248] Fiedler, *Christianity and African Culture*, p. 83, 77.

[249] Fiedler, *Christianity and African Culture*, p. 81.

[250] German missionaries from the Leipzig Mission were forced to leave the country by their opponents (British) during the World War I & II (1914 -1918 and 1939 -1945). Therefore their mission work was monitored by the Augustana Mission from USA. The indigenous people were entrusted to pastor the congregations under the supervision of the Augustana mission.

[251] Fiedler, *Christianity and African Culture,* p. 77.

[252] Fiedler, *Christianity and African Culture*, p. 78.

[253] Fiedler, *Christianity and African Culture,* p. 79, 80.

had been part and parcel of Chagga life for many years, it would take time for the leaders to educate the populace as agreed in the above-mentioned missionary meeting.

When Bruno Gutmann, a Lutheran German missionary returned to Kilimanjaro in April 1925, he was posted to Masama. His first sermon condemned the African leaders who fought against female circumcision.[254] During the missionary conference held in September 1925, Gutmann again gave a speech insisting that to abandon circumcision would encourage immorality, set back the expansion of Christianity and allow the spread of Islam.[255] In April 1926, Gutmann was transferred to pasture the congregations in Old Moshi where much of the female circumcision controversy took place. His first task in Old Moshi was to re-admit all those who were excommunicated.[256] This action and his sermon in Masama undermined the indigenous efforts to eradicate the practice, which continued to flourish despite its negative effects on women. Klaus Fiedler argues that Gutmann was not in favour of circumcision, but he never made any effort to discourage it.[257] He did not want to force the individuals to refuse the practice, with the assumption that at some point in time, they would give it up voluntarily, but this did not take place during his life time. It was not until 1972 that many Chagga parents began to refuse to allow their daughters to undergo the mutilation.[258]

In this view, Christianity endorsed female circumcision for the sake of winning converts. The effects of the practice on women were of little importance to Gutmann and this shows that he did not value the dignity of women. The reasons he gave for maintaining the rite shows that he regarded women as temptresses to men, or prostitutes, in that their sexuality was to be controlled by trimming the clitoris. The task of the gospel is to liberate individuals from all forms of oppression but Gutmann failed to use the Bible to liberate those who were oppressed by their own culture, in particular women. This

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[254] Fiedler, *Christianity and African Culture*, p. 81.
[255] Fiedler, *Christianity and African Culture*, p. 81.
[256] Fiedler, *Christianity and African Culture*, p. 82.
[257] Fiedler, *Christianity and African Culture*, p. 87.
[258] Fiedler, *Christianity and African Culture*, p. 87.

resonates with Oduyoye who argues that Christianity reinforced cultural values, which subordinate women rather than liberating them.[259]

Female circumcision continued amongst the Chagga but the communal ceremonies associated with the ritual ceased. Since Gutmann valued the male initiation teachings, he took the initiative to collect and compile them and later to incorporate them in the church's confirmation classes and in schools.[260] It is not documented whether Gutmann gave this instruction to both girls and boys or whether he exclusively taught the boys, since he only collected and compiled the teachings which related to men.

Fiedler asserts that Gutmann's colleague Georg Fritze, who arrived in Tanzania in 1927 after the First World War and worked in Mamba (east Kilimanjaro), avoided addressing the issue of circumcision too.[261] He did however arrange camps for male circumcised and uncircumcised confirmands. The camps initially lasted for seven weeks and were then reduced to three weeks.[262] Fiedler contends that Fritze was assisted by male adults including Simeon Moshi, the teacher Yakobo Lyimo of Marangu, Simeon Minja and Elifasi Mnene to organize the camps.[263] The teachings (*mapfundo*) were exclusively given by Fritze whose emphasis was on respect to elders, good behaviour and solidarity among the age group. The instruction for female confirmands was held at the mission centre once a week for the whole day.[264]

Although missionaries tried to fill the gap with regard to the initiation education, the content of the *mapfundo* offered after having been Christianized, as noted above, hardly tackled issues of marriage life in a traditional manner, which was the main focus in the old days. Parents in Mamba "objected"[265] to Fritze's work and their complaints, which were also stirred up by an African pastor, were seriously taken up by the elders, thus

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[259] Mercy Oduyoye, *Daughter of Anowa: African Women & Patriarchy*, Maryknoll: Orbis Books, 1995, p. 9.
[260] Fiedler, *Christianity and African Culture*, p. 84.
[261] Fiedler, *Christianity and African Culture,* p. 89, 90.
[262] Fiedler, *Christianity and African Culture,* p. 89, 90.
[263] Fiedler, *Christianity and African Culture,* p. 90.
[264] Fiedler, *Christianity and African Culture,* p. 91.
[265] Fiedler, *Christianity and African Culture*, p. 93.

resulting in the closure of the camp. Looking at the content of the *mapfundo,* which were offered by Fritze, it is evident that he never addressed the issues of manhood as was expected of him. This might have been the reason why parents refused to allow him to offer the instruction. Moreover, the fact that Fritze took the lead to teach instead of involving African males and females as had been done in the former days, could also be another reason associated with their complaints. In other words, parents might have wanted those teachings to be conducted by indigenous people because of cultural differences. Unfortunately no further information was offered on how the issue was resolved.

The female genital mutilation law in Tanzania falls under the Sexual Offences Special Provisions Act 1998 (SOSPA).[266] Other laws falling under this Act include sexual harassment, rape and the offence of trafficking in women. Apart from SOSPA, Tanzania is party to numerous international human rights charters and instruments that promote the protection of girls from the practice of FGM such as:

- The International Covenant on Civil and Political Rights (ICCPR)
- The International Covenant on Economic, Social and Cultural Rights (ICESCR)
- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- The Convention on the Rights of the Child (CRC) [267]

The practice of FGM is considered to be criminal if it is carried out on children under 18 years old.[268] According to the Centre for Reproductive Rights report, the FGM law states that, "any person who has the custody, charge or care of any person less than eighteen years and who causes female circumcision is guilty of the offence of cruelty to

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[266] Helen Kijo-Bisimba, "Major Laws Relating to Women's Lives,"
<http://tanzania.fes-international.de/doc/wr-major-laws.pdf >Accessed: 29/05/2007, p. 2, 3.
[267] Equality Now, "Tanzania: Enforcement of the Law Against Female Genital Mutilation,"
<http://www.equalitynow.org/english/actions/action_2002_en.html> Accessed: 05/05/2007, p.2.
[268] Kijo-Bisimba, "Major Laws Relating to Women's Lives," p. 3.

children."[269] This suggests that the mutilation for an individual above this age is lawful since she is regarded as an adult. The report also states that the punishment for this crime is imprisonment for between five and fifteen years or a fine of 300 000 Tanzania Shillings (U$D 200) or both the fine and imprisonment.

The weakness of the FGM law is that it does not protect women aged over 18 years as they can be subjected to this practice even after marriage, especially when individual marries into an ethnic group which maintain this practice. The Executive Director of the Tanzania Media Women's Association (TAMWA), Ananilea Nkya observes that girls who managed to avoid the mutilation are sometimes obliged to undergo the practice during the process of giving birth, when their mothers-in-law bribe health professionals to perform the surgery.[270] The director gave an example of her aunt who was asked by her husband to go to his home village in Mara region from Dar-es-Salaam to deliver her baby so that she could be helped by her mother-in-law as it was her first birth. As she was waiting for her baby, "her 17 year old sister-in-law informed her that she was to undergo FGM during birth, as their culture required men to only marry women who had undergone FGM."[271] This woman came to realize that her husband had conspired with his mother to ensure that she would be mutilated, since being from an ethnic group which does not circumcise women, she had not yet undergone this procedure. She therefore contacted her relatives who helped her to flee back to Dar-es-Salaam where she had her baby safely. If her sister-in-law had not mentioned this plot to this woman; she would have been subjected to the cutting at the critical moment of delivery and without her consent. Since the effects of FGM are the same for women of all ages, the amendment of this law is critical as the violation of human rights in the name of culture is evident in this practice. The survey conducted in Tanzania by Unicef in 2004/05 found that 80 percent of FGM is performed by traditional circumcisers, 14 percent by traditional birth

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[269] Center for Reproductive Rights, "Women's Reproductive Rights in Tanzania," p. 9.
[270] Gender Links, "Stop female genital mutilation-our girls deserve better,"
<http://www.citizenjournalismafrica.org.en/en.node/2783> Accessed: 29/01/2010, p. 1.
[271] Gender Links, "Stop female genital mutilation –our girls deserve better," p. 1.

attendants and 1 percent by medical personnel.[272] The participation of health workers in mutilation is referred to as the "medicalization" of the practice.[273]

While the situation above seems bleak, the Equality Now press release reports that representatives (activists) from the abovementioned NGOs convened a one-day meeting in Dar-es-Salaam at the end of May 2004, and formed a "National Coalition to End Female Genital Mutilation." Their main agenda was to urge the government to play a greater role in the efforts to eliminate the practice and to strengthen the campaigns attempting to do so. The press release goes on to say that the NGO leaders of the newly formed association planned to meet with the Minister for Community Development, Gender and Children, the Commissioner of Police and an official in the Ministry of Justice to discuss their responsibility in response to the campaign against female circumcision, and with regard to the importance of team work between the government and NGOs in this effort. It further asserts that the team met with a high-ranking police officer and insisted that he must issue the bylaws concerning the practice to local police and must also emphasize their duty to enforce these bylaws. The coalition leaders also intended to approach the ministries of Health, Education, and Local Government. [274]

As mentioned earlier, the latest 2004-05 survey highlights a slight decline in the practice from 18 percent in 1996 to 15 percent in 2005.[275] Additional evidence for the effectiveness of the NGOs in response to FGM is provided by Helen Kijo-Bisimba[276] who says:

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[272] Unicef, "Tanzania FGM/FC Country Profile," p. 2.
[273] Unicef, "Tanzania FGM/FC Country Profile," p. 2.
[274] Equality Now Press Release, "Tanzanian Activists form National Coalition to take Collective Action to end Female Genital Mutilation,"
<http://www.equalitynow.org/english/presroom/press_releases/tanzania_2004531_en.html> Accessed: 04/05/2007, p. 1.
[275] Development Gateway Foundation, "Tanzania: FGM on Decline According to a Study,"
<http://topics.developmentgateway.org/hiv/rc/ItemDetail.do~1084013?itemId=1084013>
Accessed: 02/05/2007, p. 1.
[276] Helen Kijo-Bisimba is the director of the Legal and Human Rights Centre in Tanzania.

Local NGOs attributed the decline in the number of girls undergoing FGM to continued awareness campaigns against the practice. The campaigns have had positive results, including a recent decision by 190 mutilators to lay down their tools in Kilimanjaro region.[277]

The Network Against Female Genital Mutilation (NAFGEM) is one of the local NGOs based in Kilimanjaro, and was founded in 1999.[278]

FGM in Tanzania, as elsewhere, is deeply rooted in cultural and social values which undermine the female gender in favour of men. The practice is also linked with false beliefs that mutilated women have the ability to bear more children, and that FGM will protect them from genital infections.[279] In reality, the practice is used to control women's sexuality so that they remain faithful to their husbands.[280] Although the campaigns against the practice have been documented to be fruitful to some extent,[281] some parents still want to maintain the practice for their daughters as part of their identity, irrespective of its psychological effects and the physical complications including, "repeated urinary tract infection, [and] excessive growth of scar tissue at the site of the cutting [that] causes pain during sexual intercourse."[282] A number of parents have gone to the extreme of mutilating their own infants due to the fear of being prosecuted. Some health professionals are said to be helping parents to fulfil their ambition of ensuring that their girls are cut.[283] In the past, the operation went hand in hand with education, which prepared the individuals to assume marriage responsibilities including procreation and rearing of children. The continuation of this practice due to the desire of parents, particularly the mothers, shows how women uphold culture as an essential aspect of their identity even when it oppresses and deprives them of their rights as far as sexuality is concerned. Kanyoro argues that:

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[277] Development Gateway Foundation, "Tanzania: FGM on Decline According to a Study," p. 1.

[278] Network Against Female Genital Mutilation, *Informational Brochure*.

[279] Mascarenhas, *Gender Profile of Tanzania*, p. 57.

[280] Mascarenhas, *Gender Profile of Tanzania*, p. 57.

[281] Development Gateway Foundation, "Tanzania: FGM on Decline according to a study," p. 1. See also Mukangara and Koda, *Beyond Inequalities*, p. 57.

[282] Rahman and Toubia, *Female Genital Mutilation,* p. 8, 9. See also Musimbi Kanyoro, "Feminist Theology and African Culture," in Grace Wamue and Mary Getui (eds), *Violence against Women: Reflections by Kenyan Women Theologians*, Nairobi: Acton Publishers, 1996, p. 6. Akintunde, "Female Genital Mutilation," p. 104, 105.

[283] Mascarenhas, *Gender Profile of Tanzania*, p. 57.

> Women in Africa are the custodians of cultural practices…Some perceive these practices as the essence of our culture, and therefore the centre of our identity. In other words, some believe these practices help to underpin who we are, and therefore they give us a stable base and a uniform community…These practices are harmful, oppressive and they reduce women to mere instruments of men and culture in general.[284]

Women themselves refuse to end the practice because they consider it as part of their identity irrespective of its destructive effect. Teresa Hinga therefore regards women as unconsciously being collaborators in their own oppression since they internalise practices and values that dehumanize and abuse them.[285] More awareness campaigns against the practice, directed at girls, women and the entire society are vital in eliminating it. It has been noted that a growing number of girls are resisting the practice, in that some are reported by the media to be fleeing from their homes to avoid being subjected to the cutting.[286]

An example of the implementation of the law against FGM was given in the *Mwananchi* newspaper on 16/01/2009 under the headline "*Wasota rumande kwa kumkeketa mtoto*" (In jail for mutilating a child). Pauline Richard, a journalist, reported that six women from Ilala district in Dar-es-Salaam were arrested following the charge of mutilating a girl child of 14 years old without her consent.[287] The accused were brought before the court at Ilala for the first time on 10 December 2008. During the hearing, which took place in January, all the accused denied having been involved in mutilating the girl, hence were all sent back to the prison while the court awaited information about the condition of the girl. No further developments were provided concerning the matter but the enforcement of the law is certainly a way to discourage others who might want to continue with the practice, even though an unfortunate spin-off of this is that the cutting practice has shifted from older girls and women to infants, as mentioned above.

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[284] Kanyoro, "Engendered Communal Theology," p. 161.
[285] Teresa Hinga, "Violence against Women: A Challenge to the Church," in Douglas Waruta and Hannah Kinoti (eds), *Pastoral Care in African Christianity: Challenging Essays in Pastoral Theology*, Nairobi: Acton Publishers, 1994, p. 121.
[286] Mascarenhas, *Gender Profile of Tanzania*, p. 58.
[287] Pauline Richard, "Wasota rumande kwa kumkeketa mtoto," *Mwananchi,* 16 January 2009, p. 5.

The efforts of the NGOs are commendable. Although there is a notable decline in the practice, it is essential that communal initiatives are established to bring the practice to an end. The patriarchal socialization, which has shaped women's thinking and has led them to strive for the continuation and maintenance of this culture, needs to be criticised. There is also a great need to empower young women to reject and fight against this oppressive practice. Besides FGM, early marriage is another harmful practice, which has been identified as reinforcing the spread of HIV, as will be discussed in the next section.

4.5.2.2 Early marriage

Marriage in Tanzania is regulated by the 1971 Marriage Act No. 5 which recognizes marriages contracted in a civil form, in accordance with the rites of religion (Christian or Muslim) to which both parties belong and also marriages that are contracted under customary law.[288] The law stipulates that the minimum age of marriage in Tanzania is 18 years. [289] The same law suggests that a girl can be married at the age of 15 with parental consent, and at 14 years with the permission of the court. In this case, a marriage for a girl at the age of 14 and 15 contradicts the national and international definition of a child, which is any individual who is younger than 18 years old.[290] It also contradicts the educational policy, which encourages equal access to education for both girls and boys.[291] It is this contradiction within the marriage law, which encourages early marriages in Tanzania. Although the age of marriage is clearly stated by the law, girls are married off as young as 11 years.[292] The Coast, Morogoro and Zanzibar regions are noted to have a high rate of child marriages between the ages of 11 and 15.[293] Zanzibar and the Coast region are predominantly Muslim. The Islamic law (of marriage) which is part of the Marriage Law allows the marriage of individuals who have reached puberty because they are regarded as adults.[294] It also seems to endorse the practice of girls being married

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[288] Center for Reproductive Rights, "Women's Reproductive Rights in Tanzania," p. 11.
[289] Kijo-Bisimba, "Major Laws relating to Women's lives," p. 1. See also Center for Reproductive Rights, "Women's Reproductive Rights in Tanzania," p. 12.
[290] Mascarenhas, *Gender Profile of Tanzania*, p. 58.
[291] Center for Reproductive Rights, "Women's Reproductive Rights in Tanzania," p. 13.
[292] Shekifu, "Is the Cultural Practice of Female Genital Mutilation (FGM) Compatible with Human Rights in Africa?" p. 42. See also Mascarenhas, *Gender Profile in Tanzania*, p. 58.
[293] UNHCR, "Tanzania: Prevalence of forced marriage among Christian and Muslim populations," <http://www.unchr.org/home/RSDCOI/3f7d4e2d2a.html>Accessed: 29/05/2007, p. 1.
[294] UNHCR, "Tanzania: Prevalence of forced marriage among Christian and Muslim populations," p. 1.

before they mature and without their consent. This shows that the future of a girl is dominated by marriage. In other words, she is born to be married off whether she likes it or not.

The extreme of early marriage in the Coast region is described by Tessa Peasgood et al. who contend that: "A girl could be sent to live with her in-laws even before reaching puberty so that she could get acquainted with the ways of life of his family and kin."[295] This suggests that a girl or a woman has no other value other than marriage and childbearing, a view shared by Martin Luther a mentioned earlier.[296] Furthermore, a woman is regarded as property, which can be disposed off at any time a parent (father) wishes to do so. In other words, a young woman has no freedom with regard to her future life as far as marriage is concerned. The statistics for child marriages under 18 years, which were officially registered by 2007, amounted to 42 percent.[297] This rate might be higher due to the fact that some of the marriages have not been legalized.

Women activists have highlighted two reasons accounting for early marriages in Tanzania.[298] Economic gains on the side of the girl's parents in the form of a bride price which is paid by the groom or his parents are one of the reasons. A similar incentive is maintained by other societies in Africa.[299] In some cases, these girls are married off to polygamous men who are able to pay the amount of money or possessions required.[300] This is where this cultural practice exposes the girls to HIV. Another reason for early marriage is the parents' assumption that this will solve the problem of adolescent pregnancies out of wedlock. This reveals how girls and young women are regarded as male's property being handed from the father, or brother to the husband since these men are the ones who make decisions about the girls' future life. This cultural practice

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[295] Peasgood, et al. (eds), *Gender and Primary Schooling in Tanzania*, p. 51.
[296] Wiesner, "Luther and Women," p. 127. See also Karant and Wiesner, *Luther on Women*, p. 171.
[297] Nasra Abdallah, "Serikali yatakiwa kutunga sheria mpya ya ndoa," *Tanzania Daima*, 24 September, 2007, p. 4.
[298] Peasgood, et al. (eds), *Gender and Primary Schooling in Tanzania*, p. 51, 52. See also Mascarenhas, *Gender Profile in Tanzania*, p. 58. Mukangara and Koda, *Beyond Inequalities*, p. 40.
[299] Oke, "Child Marriage: A Ticket to HIV/AIDS," p. 38, 39.
[300] Mukangara and Koda, *Beyond Inequalities,* p. 40. See also James, "The Promotion of the 'ABC' of Sex," p. 151.

violates girls' dignity and robs them of the right to enjoy their childhood. The payment of bride price has forced many women to live in abusive marriages,[301] because their own families would be forced to repay the bride price should these wives leave their abusive husbands. African women theologians critique this cultural practice because it dehumanizes women.[302]

While early marriage is a national problem in Tanzania, among the Chagga, (who are the focus of this research), my research revealed that early marriage is not an issue because the Church will only officiate marriages for girls older than 18 as per the government law.[303] Hence, the HIV and AIDS programmes of the Northern Diocese are silent on this matter. However the ideologies which govern early marriages of girls are still present even in the understanding of marriage of adult women. These ideologies range from regarding women as property, to viewing childbearing as a duty for women. The marriage liturgy of the Lutheran Church in Tanzania has adopted Paul and Peter's teachings which demand women to be submissive to their husbands and which accord men power to rule over women:

> Wives, be subject to your husbands as you are to the Lord. For the husband is the head of the wife just as Christ is the head of the church, the body which is subject to Christ, so also wives ought to be, in everything, to their husbands.[304]

Such authoritative words which are regarded as the words of God and the subsequent sermons' emphases on these instructions clearly do not reflect a partnership in marriage since one partner has power and authority over the other. While I have stated that early marriage is not an issue in Chaggaland, the practice of "unofficial polygamy" is certainly an issue, as we shall see below.

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[301] Mukangara and Koda, *Beyond Inequalities*, p. 40.
[302] Oke, "Child Marriage: A Ticket to HIV/AIDS," p. 43.
[303] Even though the church will not marry girls younger than 18, this does not mean that girls younger than 18 are not marrying outside the church, and may return to the church to have their marriages blessed after they turn 18. This is an area for further investigation.
[304] KKKT, *Mwimbieni Bwana*, Nairobi: Acme Press, 2000, p. 318, cf. 1 Col. 5:22-24 & 1Pet. 3:1-7.

4.5.2.3 Polygamy[305]

African women theologians have been at the forefront of citing polygamy as one of the key factors contributing to the spread of HIV.[306] While some scholars have argued that polygamy may actually prevent HIV due to a closed system of marriage,[307] the majority of African women theologians have argued that this system is never closed in practice.[308]

John Oliello who conducted research among his community in the Mara region also affirms that fidelity in polygamous marriage is lacking despite the traditional laws and rules which are set to govern individuals.[309] Likewise, a study conducted in Tanzania revealed that 10 percent of women in polygamous marriages are at risk of contracting HIV.[310] This is an indication that despite the number of wives a man has, he still has affairs outside the circle, which endangers the lives of all involved in such relationships. Similarly, wives in the polygamous marriages may also be tempted to seek sexual gratification outside their circle, which can lead such marriages to risk of HIV infection.

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[305] Mbiti and Kanyoro define polygamy as the practice of marrying numerous wives or marrying several times. The practice of a woman marrying more than one husband is "polyandry," but it no longer exists. John Mbiti, *African Religion and Philosophy,* 2nd edition, London: Heinemann, 1989, p. 142 and Musimbi Kanyoro, "Interpreting Old Testament Polygamy through African Eyes," in Mercy Oduyoye and Musimbi Kanyoro (eds), *The Will to Arise: Women, Tradition, and the Church in Africa*, Pietermaritzburg: Cluster Publications, 2006 , p. 88.

[306] Helen A. Labeodan, "Sexual Cultural Practices and HIV/AIDS Transmission in Nigeria: A Philosophical Appraisal," in Elizabeth Amoah, Dorcas Akitunde & Dorothy Akoto (eds), Cultural Practices: African Women's Voice, Accra: SWL Press, 2005, p. 31, 32. See also Chauke, "Theological Challenges and Ecclesiological Responses to Women Experiencing HIV/AIDS," p. 133.

[307] For example Denis says: "Polygamy is not dangerous - from an AIDS point of view - if the man limits his sexual contacts to his wives and the wives have no sexual activity outside of the marriage. This could account, at least partly, for the relatively low incidence of HIV in predominantly Muslim countries such as Senegal or Mali." Similarly Mcetywa asserts that: "The AmaMpondo practice polygamous marriages. It would be a mistake to conclude that polygamy promotes the spread of HIV/AIDS because of the assumption that such marriages are trustworthy. Like any heterosexual marriage, traditional polygamous marriage is sacred, solemn and trustworthy. Tradition has laid principles to protect such marriages from STDs and HIV/AIDS. Such rules are known by the whole society who monitors that they are followed. It is only when the rules are broken that such diseases can come in. Therefore it is not the practice of polygamy that brings HIV/AIDS but the misuse of tradition that has to be dealt with." Denis, "Sexuality and AIDS in South Africa," p. 67 and S. A. M. Mcetywa, "HIV/AIDS: A Traditional African Religious Perspective" in *Journal of Constructive Theology*, 7, 1, (2001), p. 41.

[308] Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 11, 12. See also Madipoane Masenya, "Trapped Between Two Canons: African-South African Christian Women in the HIV/AIDS Era," in Isabel Phiri, Beverley Haddad and Madipoane Masenya (eds), *African Women, HIV/AIDS and Faith Communities*, Pietermaritzburg: Cluster Publications, 2003, p. 116, 117.

[309] John K. Oliello, "The Gospel and African Culture: Polygamy as a Challenge to the Anglican Church of Tanzania-Diocese of Mara," unpublished Masters dissertation, University of KwaZulu-Natal, Pietermaritzburg, 2005, p. 84.

[310] Kessy, Mallya and Mashindano, "Tanzania," p. 217.

Whatever the reasons for polygamy, this type of marriage generally exploits and oppresses women; hence it needs to be discouraged. African feminists perceive polygamy as oppressive for women because of the patriarchal ideology associated with the practice, which regards women as male's property.[311] Since studies have affirmed a high prevalence of HIV infection in monogamous marriages[312] this means that a greater risk exists in polygamous marriages regardless of the socio-cultural rules drawn up to monitor the individuals. Anne Nasimiyu Wasike summarizes the practice of polygamy this way:

> The promotion and encouragement of polygamy were based on grounds that favoured men by boosting their personality and reducing that of women to a subservient and inferior status. The whole system supported and enhanced men's power and domination over women.[313]

The practice of polygamy still prevails in many societies in Tanzania and Africa at large. There are numerous factors making polygamy desirable in traditional societies, including procreation, the provision of a labour force, the "protection" of men from prostitution, and wife inheritance, to name a few. [314] Four major aspects of polygamy are now discussed.

4.5.2.3.1 Procreation and the preference for male children

First, in many societies in Africa, including Chagga society, marriage was considered as a duty for a man or a woman who had reached adulthood. In some societies, this was considered as something that ought to take place after the initiation ceremony, which was purposely conducted to prepare individuals for marriage and family responsibilities.[315] The main reason for marriage was childbearing. Thus each marital partner was expected to have children, and in particular male children who would perpetuate the family lineage. Without children, and preferably male children, marriage was and is considered

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[311] Kanyoro, "Engendered Communal Theology," p. 173. Labeodan, "Sexual Cultural Practices and HIV/AIDS Transmission in Nigeria," p. 30.

[312] Dube, "Grant Me Justice," p. 8.

[313] Anne Nasimiyu-Wasike, "Polygamy: A Feminist Critique," in Mercy Oduyoye and Musimbi Kanyoro (eds), *The Will to Arise: Women, Tradition, and the Church in Africa*, Pietermaritzburg: Cluster Publications, 2006, p. 102.

[314] Nasimiyu-Wasike, "Polygamy: A Feminist Critique" p. 107. See also Mbiti, *African Religion and Philosophy*, p. 143, 144.

[315] Mbiti, *African Religion and Philosophy*, p. 133, 135.

to be incomplete, which thus resulted in polygamy. This is clearly stated by Kanyoro who says, "Both in the Bible and in culture, women who do not give birth or who give birth only to girl children are diminished and find themselves perpetuating polygamy."[316] The male child in many societies in Tanzania, as elsewhere, is more valued because he is believed to keep alive the family lineage. Kanyoro also asserts that, "Polygamy, therefore, ensured a constant source of procreative gratification to men…Polygamy also guaranteed that men would have descendants in their names."[317] Barrenness was and is counted as a woman's misfortune, thus she must carry all the blame for infertility on her shoulders. The next section will explore cheap labour and prestige as another issue that promotes polygamy in some societies in Tanzania as in other parts of Africa.

4.5.2.3.2 Labour force and prestige

Secondly, polygamy was also encouraged in order to have sufficient labour force on the farms and for animal pasturing.[318] In other words, it was a means for a man to accumulate wealth. Thus, additional wives and children born to these wives were required to share the labour burden within their households as well as with regard to the farm and livestock. These views agree with Silas Oyaro[319] from Kisumu (Kenya) and Oliello[320] from Mara (Tanzania) who state that a man became richer and acquired prestige or great influence according to the vast number of wives and children he had, as the burden of economic labour lay on their shoulders. The Mara region has the highest rate of

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[316] Kanyoro, *Introducing Feminist Cultural Hermeneutics,* p. 86. See also Kanyoro, "Engendered Communal Theology," p. 172.

[317] Kanyoro, "Interpreting Old Testament Polygamy…" p. 96. See also Benezeri Kisembo, Laurenti Magesa and Aylward Shorter, *African Christian Marriage*, London: Geoffrey Chapman, 1977, p. 64.

[318] Eunice R. Kisija, "The Impact of Tradition on Rural Women in Tanzania," in Ruth Besha (ed), African Women: Our Burdens and Struggles, Johannesburg: Institute for African Alternatives, 1994, p. 28. See also Nasimiyu- Wasike, "Polygamy: A Feminist Critique," p.105. Judith Bahemuka, "Social Changes and Women's Attitudes toward Marriage in East Africa," in Mercy Oduyoye and Musimbi Kanyoro (eds*), The The Will to Arise: Women, Tradition, and the Church in Africa*, Pietermaritzburg: Cluster Publications, 2006, p. 124. Masamba ma Mpolo. "Cultural Collisions: A Perspective from Africa," in Howard Stone and William Clements (eds), *Handbook for Basic Types of Pastoral Care and Counselling*, Nashville: Abingdon Press, 1991, p. 106.

[319] Silas Oyaro, "Motivation and Strategies for the holistic church intervention in care-giving to AIDS widows in Kisumu, Kenya," unpublished Masters dissertation, University of KwaZulu-Natal, Pietermaritzburg, 2004, p. 28.

[320] Oliello, 'The Gospel and African Culture," p. 76.

polygamy in Tanzania, at about 48.9 percent of marriages.[321] Oliello asserts that a man in Mara region could marry up to twenty or fifty wives.[322] The Luo, Kurya, and Jita are the main ethnic groups in Mara region. The Luo in Mara (Tanzania) and Kisumu (Kenya) share the same culture of polygamy as part of their identity. This suggests that the Luo proverb which emanates from Kenya and which affirms polygamy by comparing "a man with one wife to having only one eye"[323] is maintained by the Luo in Tanzania.

Furthermore, the prestige of acquiring a number of wives is expressed by an older Gogo[324] man as follows: "Our customs allow us to have up to five wives and have as many as 20 children. This gives [a man] more respect in the community – as a real man, father and leader of a big *boma* (household)."[325] Having several wives and children is thus a source of great status. However, this same Gogo older man cautions about the threat of HIV associated with this kind of marriage, as well as the economic hardship which makes it difficult even to maintain a nuclear family.[326] The latter argument, if taken into consideration, can serve to eliminate polygamy within communities who strongly regard polygamy as part of their culture. Traditionally, polygamy among the Chagga involved a few wealth people and leaders (for example chiefs in Kilimanjaro) who were able to acquire a large portion of land and a number of herds of cattle, sheep, and goats. To maintain this practice today is difficulty economically, especially for less wealthy people as pointed by the older Gogo man.

In my view this category of the justification of polygamy indicates that those women were considered as servants or cheap labour and not partners in marriage, because whatever they produced was for the glory and benefit of the men. The practice shows the patriarchal male dominance over women and children. Kanyoro argues that, "Polygamy has tended to exploit women and children's labour because [it] is justified as a means of

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[321] Women's Control of Resources and Caring Capacity, <http://www.unsystem.org/SCN/archives/tanzania/ch11.htm> Accessed: 29/05/2007, p. 2.
[322] Oliello, "The Gospel and African Culture," p. 83.
[323] Rakoczy, *Women Doing Theology,* p. 287.
[324] The Gogo or Wagogo (pl.) is the main ethnic group in Dodoma region – central Tanzania.
[325] Irin, "A Century later, little has changed for most females," <http://www.tanzaniagateway.org/docs/century_with_woman.pdf> 09/05/2007, p. 1.
[326] Irin, "A Century later, little has changed for most females," p. 1.

enhancing productivity of property for the man."[327] A man acquires prestige through the labour of women and children. The most negative aspect of this is that these women and children are denied the right to have control over the fruits of their production because of the patriarchal structure which accords males the right to own property. Wife inheritance was and remains another factor which perpetuates polygamy in many societies, as will be examined below.

4.5.2.3.3 Wife inheritance

The inheritance of a wife of a deceased man by a brother or a close member of the family (levirate marriage) was another factor accounting for polygamy.[328] The brother of the deceased husband, whether he is married or not, is responsible for all the duties of a husband and father of the house. In cases where the man is not married he still has the right to marry a wife of his choice besides the one he inherits from his brother. The reason behind this practice which prevails in many parts of Africa is claimed "to protect the widow by taking care of her material and as well as sexual needs."[329] This practice again reveals the male dominance over women in all aspects of their lives including their sexuality. It shows that a woman has no freedom to decide about her own life; instead decisions are made for her. This practice was probably seen as relevant in the past, but in the context of HIV, it poses a threat to both partners. If one partner is living with the virus, he/she would obviously pass on the virus to the other. This is clearly illustrated by Nicolson who says:

> Traditional practices like polygamy or the inheritance by a man of his brother's widow may in the past have been seen as giving protection to women, but in reality they often lead to women having very little say over their own lives and little say over their sexual relationships. It is extremely difficult for women to insist that their men use condoms, or to question any sexual

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[327] Kanyoro, *Introducing Feminist Cultural Hermeneuti cs*, p. 86.

[328] Mbiti, *African Religion and Philosophy*, p. 144. See also ma Mpolo, "Cultural Collisions: A Perspective from Africa," p. 107. Reggy –Mamo, "Levirate Custom and HIV/AIDS: A Personal Experience," p. 49.

[329] Laurenti Magesa, "Taking Culture seriously: Recognizing the reality of African Religion in Tanzania," in James F. Keenan (ed), *Catholic Ethics on HIV/AIDS Prevention*, New York: Continuum, 2000, p. 80. See also Esther Mombo, "HIV/AIDS in the context of Levirate Marriage," in Lutheran World Information, No. 11, (2005), p. 23. Kimani, "Human Sexuality," p. 408.

relationships, which their men might have outside of their relationships. This certainly contributes significantly to the spread of AIDS.[330]

Concerning the situation of widows in Tanzania, Ophelia Mascarenhas argues that despite the fact that the Tanzanian government has agreed to eliminate all forms of discrimination against women, and to remove all laws, customs and practices that are discriminatory by signing the convention for the Elimination of Discrimination Against Women (CEDAW), this issue of wife inheritance has still not been debated by Tanzania's Commission for Human Rights.[331] The silence on this matter may be attributed to what can be termed the interference of the male dominated system, meaning that males who dominate decision-making bodies, do not wish to institute changes and bring about equality in this regard. Kanyoro therefore suggests that, "when dealing with cultural matters, there is a need for collective solidarity. Cultural oppression cannot be addressed in singularity."[332] Her suggestion is crucial because strength is found in numbers when challenging long-held assumptions, and thus both men and women need to be well informed about the negative impact of the practice so that all can participate in bringing about changes for the benefit of the community. In my research the practice of wife inheritance among the Chagga was revealed even though it is practiced secretly.

4.5.2.4 Obligatory sex in marital relationships and multiple partners for men
Another destructive cultural practice is the belief that sex is a woman's duty and a man's right.[333] This is coupled with the assumption that men need and have the right to regular sexual intercourse with a variety of partners. In the traditional Chagga societies, a bride price or marriage gift was given by the family of the man to the family of the woman before marriage could take place.[334] The bride price was regarded as a link between the two families. It also helped to underpin the marriage since neither of the two partners

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[330] Ronald Nicolson, *AIDS: A Christian Response*, Pietermaritzburg: Cluster Publications, 1995, p. 47. See also Hazel Ayanga, "Religion and Women's Health," in Musimbi Kanyoro and Nyambura Njoroge (eds), *Groaning in Faith: African women in the Household of God*, Nairobi: Acton Publishers, 1996, p. 212.
[331] Mascarenhas, *Gender Profile of Tanzania*, p. 55.
[332] Kanyoro, "Cultural hermeneutics: An African Contribution," p. 106.
[333] Ronald Nicolson, "God in AIDS? five years later" in *Bulletin for Contextual Theology in Africa,* 7, 1, (March 2000), p.11.
[334] Lema*, The Foundation of the Lutheran Church in Kilimanjaro*, p. 308.

could decide to break up the marriage in the event of any quarrel without the two families coming together to try to resolve the matter. In other societies, like that of the Sukuma[335] who reside in Tabora, Mwanza and Shinyanga regions, the amount of bride price depends on the skin colour of the girl and her education.[336] Eunice Rose Kisija maintains that a high bride price is paid for a brown girl and an educated one, while the darker–skinned girl one obtains a low payment.[337] In Mara region near Lake Victoria which is highly populated by the Luo and Kurya, a groom pays up to 60 cows to get a wife.[338] A woman in such a kind of marriage cannot easily divorce in cases of gender-based violence or abuse because the bride price would then have to be paid.

Commenting on the same issue, Madipoane Masenya argues that the marriage gifts in many societies have become more or less a commercial aspect of marriage that has warranted men's authority to control women's bodies and their sexuality.[339] She further argues that, "In this new setting, a woman is no longer her own person but belongs to the man and his family. Even her sexuality belongs to the one who gave the *lobola* (bride price)."[340] In this regard, a woman cannot negotiate for safer sex. A woman might be aware of the unfaithfulness of her partner but the moment she questions this or insists on the use of a condom, it ends up in violence.

Besides the abovementioned reasons, it has been observed that the traditional Chagga practice of polygamy has taken on a new form, which is known as "*nyumba ndogo*," literally rendered as "small houses." This has no connection to childlessness or having children of one gender (girls only). Instead, it presents a cultural shift whereby married males, who have migrated to other parts of the country, and even those who remain within their own localities, have extra marital affairs and children with particular women

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[335] Sukuma (Wasukuma pl.) is the largest ethnic group in Tanzania which accounting to 13% of the population in Tanzania.
[336] Kisija, "The Impact of Tradition on Rural Women in Tanzania," p. 27.
[337] Kisija, "The Impact of Tradition on Rural Women in Tanzania," p. 27.
[338] Alfred Mbogora, "Tanzania: Women activists link dowries to wife battering," <http://www.highbeam.com/doc/1P1-20035982.html>Accessed: 14/07/2009, p. 1.
[339] Masenya, "Trapped Between Two Canons," p.122.
[340] Masenya, "Trapped Between Two Canons," p.122. See also Usdin, *No-Nonsense guide to HIV/AIDS*, p. 52.

who are kept as unofficial wives. This perception has gained support from Philip Setel who affirms that, "Over the years many of these men had established other lives and other wives in such cities as Dar-es-Salaam, Mwanza, Morogoro and Mbeya."[341] Men within such relationships still maintain their formal or official marital home where they regularly visit or live. This practice, which is a major cause of the spread of HIV in this society, is apparently acceptable as a norm since no efforts are made to combat it. Although Chagga married women might be faithful in their marriages as culture dictates them to be, they are at high risk of HIV infection because when their husbands demand sex with them they are not in a position to insist on safer sex, or to question their husbands about their HIV status due to fear of violence or abandonment. Setel observes the dilemma of married women in this situation, stating that, "The wives of long-absent men often expressed deep anxiety about their vulnerability to HIV infection at their husband's annual visits home."[342] This statement confirms the powerlessness of women to confront their spouses, and also the lack of any social system that can protect them from the consequences should they attempt to refuse to have sex with their husbands. Such gender power imbalances have contributed to the high rate of HIV infection and deaths among married couples, and hence to higher number of orphans. Phiri argues that this behaviour of African men of continuing to have sexual relations with other partners besides their official ones is attributed to patriarchal African culture which regards women as inferior to men.[343] It will therefore be important to analyze later how and whether the HIV and AIDS programmes are responding to this gendered issue.

To conclude this section on polygamy, it must be said that the ELCT Northern Diocese does not permit polygamous marriages. Nevertheless, my research revealed that "unofficial polygamy" exists amongst the Chagga who are also Christians. Hence, I will examine in subsequent chapters how and whether the HIV and AIDS programmes take these factors into consideration in the design and implementation of their policy and programmes.

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[341] Setel, "Local Histories of Sexually Transmitted Diseases and AIDS in Western and Northern Tanzania," p. 135.
[342] Setel, "Local Histories of Sexually transmitted Diseases and AIDS in Western and Northern Tanzania," p. 135.
[343] Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 12.

Having discussed three cultural factors, namely FGM, early marriage and polygamy which contribute to the prevalence of HIV in Tanzania, I now turn my attention to sketching the response of the government to the prevalence of HIV in Tanzania. The reason for examining the government's response here is to set the scene for a comparison between the HIV and AIDS programmes of the church and the government's programmes. This comparison will be dealt with in subsequent chapters.

4.6 The National Response to HIV and AIDS

The government has taken various steps to curb the spread of HIV. The Ministry of Health (MOH) made the initial attempts in this regard as the pandemic was considered to be a health problem.[344] In 1985 the AIDS Task Force was established under the Ministry of Health which 1988 became the National AIDS Control Programme (NACP). The AIDS Task Force and later the NACP devised the Short Term Plan (1985-1986), and three Medium Term Plans (MTP), lasting for five years each: MTP-1(1987-1991), MTP-2 (1992-1996) and MTP-3 (1998-2002).[345] To initiate the implementation of the Medium Term Plan One (MTP-1), the NACP launched four technical units, and one management unit to address the challenges posed by the pandemic. These units include those for Information, Education and Communication (IEC), Laboratory and Blood Transfusion, Clinical Services, Epidemiology and Research, and Management.[346] The NACP states that a sixth unit, Counselling and Social Support was founded in 1990 due to the immense number of sick people due to HIV and AIDS related illnesses.

The decentralisation of HIV and AIDS activities was crucial during MTP-1. Therefore, twenty Regional and one hundred and three District AIDS Control Co-ordinators (RACCS and DACCS) were appointed at a meeting of heads of departments from the MOH, Regional Medical Officers (RMOs) and other health officials which took place in 1987.[347] Furthermore, the evaluation of MTP–1 was conducted in 1991, and this

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[344] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 3. See also Bujra and Baylies, "Responses to the AIDS pandemic in Tanzania and Zambia," p. 33.
[345] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p.3. Tanzania National Website, "HIV/AIDS in Tanzania," p. 2. {NACP} National Response, "Milestones of National Response," p.1.
[346] {NACP} National Response, "Milestone of National Response," p. 1.
[347] {NACP} National Response, "Milestone of National Response," p. 2.

identified constraints and recommendations for the next MTP. The recommendations drawn up by the review team included "decentralisation, multi-sectoral involvement, community mobilisation and NGO involvement as the main strategies of MTP-2."[348] According to the Commonwealth Secretariat:

> A multi-sectoral response means involving all sectors of society - governments, business, civil society organisations, communities and people living with HIV/AIDS - at all levels - pan-Commonwealth, national and community - in addressing the causes and impact of the HIV/AIDS pandemic. Such a response requires action to engender political will, leadership and co-ordination, and to develop and sustain new partnerships and ways of working, [as well as] and to strengthen the capacity of all sectors to make an effective contribution.[349]

A multi-sectoral approach to combat HIV and AIDS was agreed to by governments in their Declaration of Commitment at the June 2001 United Nations General Assembly Special Session on HIV and AIDS.[350] This agreement was reached due to the fact that HIV and AIDS was recognized as a threat pervading all aspects of human life, hence requiring joint efforts from all sectors of society to address it.

The HIV and AIDS National Response report asserts that the Medium Term Plan Two (1992-1996) involved other sectors in the national efforts to control HIV and AIDS.[351] Initially seventeen public and private sectors had joined, but by 2003 twenty-three more sectors came on board. These sectors have established HIV and AIDS action plans comprising all the districts within the country.[352] Janet Bujra and Carolyn Baylies assert that the evaluation of MTP–2 acknowledged the high levels of HIV and AIDS awareness among the population.[353]

The report further explains that under the auspices of the Third Medium Term Plan (1998-2002) numerous initiatives took place. First, in 1998, the Ministry of Health issued

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[348] {NACP} National Response, "Milestone of National Response," p. 2.
[349] Commonwealth Secretariat, *Gender Mainstreaming in HIV/AIDS*, p. 51.
[350] Commonwealth Secretariat, *Gender Mainstreaming in HIV/AIDS*, p. 51.
[351] {NACP} National Response, "Milestones of National Response," p. 3.
[352] {NACP} National Response, "Milestones of National Response," p. 3.
[353] Bujra and Baylies, "Responses to the AIDS pandemic in Tanzania and Zambia," p. 33.

a strategic frame of reference for the prevention and control of HIV and AIDS and sexually transmitted infections to be used during the third term. Second, the former Prime Minister Hon. Sumaye launched the MTP-3, aiming to provide multi-sectoral co-ordination from national to grass root levels. In this regard, each public institution was required to create a Technical AIDS Committee (TAC) to tackle HIV and AIDS matters in their institutional context.

In 1999, President Mkapa declared HIV and AIDS as a national disaster.[354] This led to the establishment of the Tanzania Commission for AIDS (TACAIDS) in 2001, which was responsible for providing leadership and coordination of multi-sectoral responses. This was followed by the inauguration of a national Policy on HIV and AIDS in November 2001. In this respect, all the national efforts were translated into the National HIV and AIDS Multi-sectoral Strategic Framework (NMSF), a four-year plan stretching from 2003 to 2006. The NACP remains a technical wing of the Ministry of Health, with special focus on the control and prevention of HIV and AIDS, and sexually transmitted infections.[355] Although the government was clearly keen to establish various instruments to counteract the pandemic, it overlooked gender issues, which are central to the transmission of the pandemic.

However, this was to an extent remedied when in July 2007; the government launched its second National Multi-sectoral Framework (NMSF) on HIV and AIDS to cover three years from 2008 to 2010.[356] The main focus of this second NMSF is to mitigate HIV infection among the populations considered to be at risk due to "gender inequality, sexual abuse, socio-cultural factors, women engaging in commercial as well as transactional sex, sexually abused children, widows, divorcees, prisoners, refugees, displaced people,

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[354] Tume ya Kudhibiti UKIMWI (TACAIDS), *Mkakati wa taifa wa Kudhibiti UKIMWI 2003-2007*, Toleo la Pili, Dar-es-Salaam, (Desemba 2004), p. v. See also Kessy, Mallya and Mashindano, "Tanzania," p. 222.
[355] {NACP} National Response, "Milestones of National Response," p. 4.
[356] UNAIDS/TACAIDS, "UNGASS Country Progress Report: Tanzania Mainland in 2008 progress reports submitted by countries,"
<http://data.Unaids.org/pub/Report/2008/tanzania_2008_county_Progress_report_en_pdf> Accessed: 15/07/2009, p. 14. See also UNAIDS, "Regional Support Team for Eastern and Southern Africa," <http://www.unaidsrstesa.org.countries/tanzania>Accessed: 26/07/2009, p. 1.

people with disabilities and intravenous drug users."[357] It is true that some populations are vulnerable to HIV infection due to gender disparity, violence, poverty, war, conflicts, age and disability, but the report fails to acknowledge that every individual who is sexually active is at risk of being infected with HIV. Moreover, the report did not explain the strategies that will be employed to address the plight of the above-mentioned categories of people. The report also assumes that it is only women who are involved in commercial sex work and transactional sex; hence failing to underline that it is their male clients who are the source of the problem. It is this gender stereotype that makes HIV and AIDS programmes ineffective. I argue along with Rao Gupta that this gender stereotyping which considers women as prostitutes as opposed to their male partners is the major barrier in fighting against HIV and AIDS. Initiatives to address both genders are essential since each plays a significant role in facilitating the spread of HIV. In this regard, the government strategies to respond to the effects of the pandemic have to adopt more gender sensitive programmes if at all they are to halt the pandemic. Some of the programmes, which were part of the three Medium Term Plans to mitigate the effects of the pandemic, will be explored in the next section.

4.6.1 HIV and AIDS education awareness

HIV and AIDS education was identified as the major tool in responding to the spread of the pandemic in Tanzania. One of the units established by the NACP in response to the pandemic was the Information, Education, and Communication unit (IEC). This unit was liable for collecting data and facts about HIV and AIDS, circulating relevant information, running awareness campaigns and providing education to the populace about the pandemic.[358] The importance of HIV and AIDS awareness is also stressed by Sonja Weinreich and Christoph Benn who assert that:

> Information, Education and Communication (IEC) are indispensable for conveying to people knowledge about AIDS. In countries where prevention has been successfully implemented, an education component generally forms an essential part of their interventions.[359]

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[357] UNAIDS, "UNGASS Country Progress Report: Tanzania Mainland," p. 14.
[358] Juma, *Coping with HIV/AIDS in Education*, p. 6.
[359] Weinreich and Benn, *AIDS-Meeting the Challenge,* p. 59.

Magdalen Juma states that HIV and AIDS education was first conveyed through the mass media, during the implementation of the first national Medium Term Plan (1987-1991)[360] as mentioned earlier. She goes further to say that HIV and AIDS education was later introduced in workplaces mainly in the urban settings, and in schools, as planned for in the second Medium Term Plan (1992-1996). However, Bujra and Baylies contend that at the end of 1998 an HIV and AIDS curriculum for primary schools had still not been established.[361] They also argue that though there was a lively programme of educational work in some communities, gender awareness was lacking and problematic sexual behaviour among young people was not acknowledged or addressed. However, peer education initiatives were employed for specific groups such as women, traders, school leavers, factory and sex workers, to make them aware of the danger of HIV and AIDS and of the means of protection from infection. Weinreich and Benn echo the importance of peer education stating that:

> Messages about HIV and sexuality are generally more readily accepted when they come from a member of one's own group (e.g. among school children when they come from classmates). Trust is greater here, because such a person comes from the same situation, and thus understands one's own problems.[362]

Juma describes why HIV and AIDS education is such an effective strategy in coping with the pandemic.[363] Firstly, education prevents or delays young people from engaging in premature sexual activity, which then minimizes their chances of infection. Secondly, education enables people living with HIV and AIDS to live positive and healthy lives. Thirdly, education assists the family to cope with grief and the loss of any member of the family, be it a parent, a child or a breadwinner. Finally, education empowers marginalized groups, such as women, to challenge oppressive structures or culture, which put them at risk of HIV infection. Through challenging such structures and their associated practices, they can gain control over their bodies, the right to own property, and access to education and employment. In relation to the latter strategy it is hard to

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[360] Juma, *Coping with HIV/AIDS in Education*, p. 7.
[361] Bujra and Baylies, "Response to the AIDS pandemic in Tanzania and Zambia," p. 37.
[362] Weinreich and Benn, *AIDS- Meeting the Challenges*, p. 60.
[363] Juma, *Coping with HIV/AIDS in Education*, p. 8.

assess to what extent this education and awareness has given women the courage to challenge the patriarchal structures which still pervades all levels of society.

Various non-governmental organisations (NGOs) and government departments are engaged in HIV and AIDS education programmes. Juma asserts that NGOs function with different strategies and in different places. Seminars, peer education, counselling, campaign rallies, church-based education, posters and leaflets are common teaching methods employed by the NGOs for the general public. Meanwhile, in primary schools, trained teachers and guest speakers, such as health workers or educators from various organisations within the area, use lecture and discussion methods. [364]

Fenella Mukangara and Bertha Koda observe that most of the HIV and AIDS programmes of government and NGOs are directed at adults, specifically sex workers, truck drivers and workers in public sectors, thus ignoring the out-of-school youth, informal sector entrepreneurs and rural-based community.[365] This highlights the limitations of these programmes since this categorization denies the majority of the populace the opportunity of acquiring accurate information in order to protect themselves from HIV infection. However, out-of-school youth do access some learning through radios, television programmes, church teachings, pamphlets, and their peers.[366] Although these opportunities are available, the presence of trained personnel to guide and clarify to them some of the issues with regard to their sexuality could have been more appropriate than leaving this education to their peers and to the media, both which may be skewed or even incorrect in their approaches. Care for PLWHA is another programme highlighted by the national HIV and AIDS policy as a strategy to responding to the pandemic. This is the issue to which I now turn.

4.6.2 Care for people living with HIV and AIDS
HIV and AIDS has placed an enormous care burden on the family members or the community concerned, whether the sick person is at home or hospitalised. Much time and

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[364] Juma, *Coping with HIV/AIDS in Education*, p. 61, 62.
[365] Mukangara and Koda, *Beyond Inequalities,* p. 54.
[366] Mukangara and Koda, *Beyond Inequalities*, p. 54.

resources are spent, putting people in debt or forcing them to sell some of their assets to cope with the situation.[367] However, family members such as widows and children also need care and support while nursing their sick and after the loss of their loved ones. The main purpose of the national policy on HIV and AIDS in relation to care is "to promote appropriate nutritional, social and moral support to PLWHA to enable them to enjoy a good quality of life, remain productive and live much longer with HIV/AIDS."[368] The policy notes the government's inability to create systems that can provide such support. However, it acknowledges the efforts of the community, non-governmental organisations (NGOs), community based organisations (CBOs), faith groups and private sectors in supporting people living with HIV and AIDS in various ways. This is echoed by Weinreich and Benn who state that, "Home care is essentially borne by NGOs and community groups, in particular the churches, and on the whole government participation in these programmes is rather low."[369]

Home-based care for PLWHA as well as other diseases fall disproportionately on women and girls due to the traditional gender-based division of labour. Women are not giving care to their own sick relatives only but they also are a majority among those who provide care within the communities through the CBOs and NGOs and in most cases on a voluntary basis.[370] The magnitude of the HIV and AIDS pandemic demands that both men and women be involved in giving care to sick family members in order to minimize burnout and give women an opportunity to participate in other productive activities as well.

Moreover, the policy states that counselling and access to information services are major components in programmes that aim to guide individuals towards living positively with their HIV and AIDS status and protecting themselves and others from further transmission. It adds that providing care will also lead PLWHA to participate fully in

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[367] Lori Bollinger, John Stover and Peter Riwa, "The Economic Impact of AIDS in Tanzania," <http://www.policyproject.com/pubs/SEImpact/tanzania.pdf>Accessed: 23/04/2007, p. 5.

[368] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 26.

[369] Weinreich and Benn, *AIDS - Meeting the Challenge*, p. 75.

[370] Weinreich and Benn, *AIDS – Meeting the Challenge*, p. 75. See also Quarraisha A. Karim et al. "Home-Based Care," in Max Essex, et al. (eds), *AIDS in Africa,* 2nd edition, New York: Kluwer Academic, 2002, p. 416. Poku, *AIDS in Africa,* p. 99.

community activities. Furthermore, it urges care providing institutions and communities to offer their care for PLWHA without discrimination. Besides care for PLWHA, human rights and gender issues were also singled out as relevant components in the addressing of HIV and AIDS.

It is clear from the above that the government has policies on care-giving but it does not have practical programmes which enable this care-giving to take place. Instead, it lays this responsibility at the door of CBO's and NGO's. While it does not specify faith-based organisations, it is perhaps this gap that the HIV and AIDS programmes of ELCT Northern Diocese are filling. The question is to what extent they are taking on the responsibility of care-giving successfully and do they affect the gendered nature of care-giving?

4.6.3 Human rights and gender issues

The third programmatic area in which the government is involved is that of human rights and gender issues. The National Policy on HIV and AIDS stipulates the rights of PLWHA in order to improve their quality of lives and reduce stigma associated with the pandemic. These rights include the right to non-discrimination, confidentiality, education, employment, health care, and other social services as well as the right to marry and found family.[371] The HIV and AIDS policy notes that the government will work hand in hand with the international community and UNAIDS in re-evaluating guidelines on human rights and HIV and AIDS.

Human rights apply to all people worldwide and are stated in various international instruments including:

- The Universal Declaration on Human Rights,
- The Covenant on Economic Social and Cultural Rights,
- The Covenant on Civil and Political Rights.

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[371] The United Republic of Tanzania, *The National Policy on HIV/AIDS*, p. 14.

- The Convention on the Elimination of all Forms of Discrimination against Women;
- The International Convention on the Rights of the Child. [372]

Sophia Gruskin and Miriam Maluwa argue that human rights apply to all human beings worldwide, and are basically concerned with the relationship between the person and the state.[373] They further contend that governments are responsible for creating an environment which enables individuals to comprehend their rights; and that they are liable to respect, protect and fulfil human rights. The HIV and AIDS pandemic and human rights are linked with one another in a variety of ways, and the human rights of individuals living with HIV and AIDS are likely to be violated through discrimination and prejudice against them.[374] Since the stigmatization of and discrimination against PLWHA contribute to people's continued silence on their status, it can be argued that the violation of human rights, therefore, adds to the susceptibility to and risk of infection. In this regard, Weinreich and Benn further indicate that:

> The UN Commission on Human Rights, referring to human rights laws, declared in its resolutions that discrimination against a person on the basis of that person's health status - including HIV/AIDS – is inadmissible. Therefore, discrimination against people living with HIV is a violation of their human rights.[375]

Despite the underlying human rights, as emphasised by the international and national instruments available to the government, this issue remains at a theoretical level of policy, because in practice the rights of the majority of people living with HIV and AIDS in Tanzania are violated in various ways as will be examined below.

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[372] Weinreich and Benn, *AIDS - Meeting the Challenge*, p. 50. See also Mwaura, "Violation of Human Rights of Kenyan Women with HIV/AIDS through Stigma and Discrimination," p. 130.

[373] Sofia Gruskin and Miriam Maluwa, "Human Rights and HIV/AIDS," in Max Essex et al. (eds), *AIDS in Africa*, 2nd edition, New York: Kluwer Academic, 2002, p. 642, 644. See also Weinreich and Benn, *AIDS – Meeting the Challenge*, p. 50.

[374] Weinreich and Benn, *AIDS – Meeting the Challenge*, p. 50.

[375] Weinreich and Benn, *AIDS – Meeting the Challenge*, p. 50.

4.6.3.1 Stigma and discrimination

One of the most important examples of how human rights are violated is the way PLWHA are stigmatized and discriminated against in - households, the workplace, schools and the community,[376] despite the wide knowledge on how HIV in transmitted and how one can avoid infection. A survey conducted in some communities in Dar-es-Salaam acknowledges the prevalence of social, physical, verbal and institutional stigma among the population studied.[377] Social and physical stigma occurs when individuals are excluded from family and community events and relationships. It also relates to the separation of bedrooms or sleeping quarters, utensils, clothing and bed linen. Verbal stigma includes gossip and being called by various names. An example of the stigmatizing language used to name a person living with HIV and AIDS in Tanzania is *nyambizi* (submarine), which means that the person may be fatal to others and is a hazard.[378]

Furthermore, institutional stigma also exists and this becomes apparent in the loss of resources and livelihoods. Loss of resources includes the loss of employment, being evicted from a rented house or room, denial of treatment or medication, as well as of training and promotion.[379] Loss of livelihood happens to the vendors who lose their customers after their HIV status has become known. Some of them are selling food, fruits and vegetables, products that customers would not under any circumstances dare to buy if they suspect the person is HIV positive. The research also noted a gender-based stigma in that women experienced various forms of stigma more strongly than their male counterparts, because of their low status in society.[380] Some women have been abandoned by their spouses or families and property has been taken away from them after they have

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[376] Kessy, Mallya and Mashindano, "Tanzania," p. 252. See also Tanzania Stigma Indicators Field Group, "Working Report measuring HIV Stigma: Results of a field test in Tanzania June 2005," <http://www.icrw.org/docs/2005-stigmaIndicatorsReport.pdf> Accessed: 19/08/2009, p. 42. Mascarenhas, *Gender Profile of Tanzania*, p. 49.

[377] Tanzania Stigma Indicators Field Group, "Working report measuring HIV Stigma," p. 42.

[378] William Rankin, et al. (eds), "The Stigma of Being HIV-Positive in Africa: HIV-related stigma is fuelling the pandemic, and disempowering women even further," <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.137/journal...> >Accessed: 13/04/2008, p. 3.

[379] Tanzania Stigma Indicators Field Group, "Working Report measuring HIV Stigma," p. 42.

[380] Tanzania Stigma Indicators Field Group, "Working Report measuring HIV stigma," p. 103.

been diagnosed HIV positive. Others have been threatened with violence, while others have been again verbally abused. The abandonment of married women, due to their HIV status, has been documented by various studies elsewhere in Africa.[381] This aspect was also evident in my findings.

The existence of stigma and discrimination has been identified as the major obstacles to HIV prevention, care, treatment and social support for PLWHA.[382] Hence, people fear going for HIV testing and those aware of their HIV-positive status do not disclose it to their spouses, a situation which facilitates the transmission of HIV.

A study conducted in Tanzania between 2007/08 shows that only 37 percent of women and 27 percent of men have been tested for HIV and received results.[383] Stigma is the underlying reason why not more use is made of this crucial service. Some individuals have decided to cut short their lives due to high levels of stigma, as in the case of Mwashitete. The *Nipashe* newspaper of 10/03/2008 under the headline: "*Nimejinyonga sababu ndugu wananinyanyapaa*" (I have committed suicide because my relatives stigmatize me) reveals the effect of stigma in our contemporary society. Gerard Mwashitete, aged 48 years, and a resident of Kimara, Dar-es-Salaam, terminated his life on 8th March 2008, leaving behind a message which said, "I have committed suicide because my relatives and my family members have isolated me."[384] The editor further explains that Mwashitete was living with HIV and AIDS and lost his wife two years previously to HIV and AIDS related illnesses. This case highlights the experience of the violation of human rights through the stigma associated with HIV and AIDS and the consequences thereof. In fact, Mwashitete is just one among many PLWHA, rejected by family members and society because of their status. The fact that the pandemic is associated with promiscuity; means that it will take time for individuals to change their

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[381] Moyo, "Gendered Stigma," p. 130. See also Karim, "Home – Based Care," p. 416. Dube, "Grant Me Justice," p. 11.

[382] UNAIDS, A Conceptual framework and basis for action: HIV/AIDS stigma and discrimination, June 2002, p. 5. See also Mascarenhas, *Gender Profile of Tanzania*, p. 48. Gruskin and Maluwa, "Human Rights and HIV/AIDS," p. 641.

[383] UNAIDS, "First EAC Regional HIV Prevention Experts Think Tank," p. 10.

[384] Hellen Mwango, "Nimejinyonga sababu ndugu wananinyanyapaa," <http://ww.ippmedia.com/ipp/nipashe/2008/03/10/110045.html> Accessed: 10/03/2008, p. 1.

negative attitude towards PLWHA although often those who stigmatise others have themselves not gone for HIV tests. Violation of human rights is also apparent in the fact some members of the population are unable to access treatment of HIV and AIDS, which is the subject our following discussion.

4.6.3.2 Failure to access health care services

While the government policy on HIV and AIDS declares that PLWHA should have access to treatment, in practice not all PLWHA have access to medical services[385] which might be attributed to poor infrastructure, stigma or the limited capacity of health-care institutions, due to financial constraints of a state. Tanzania, as other African countries, is a signatory of the UN human rights instruments[386] so that it is responsible for fulfilling all human rights including the allocation of sufficient funds to meet the public health needs of its citizens. Unfortunately, the country's financial crisis has hampered the availability of adequate HIV testing sites across the country, and hence the treatment of opportunistic infections, prevention of mother to child transmission of HIV and the provision of antiretroviral drugs to all individuals in need of them.[387] For example, by the end of 2009 there were only 2 134 VCT sites across the country[388] which is low in relation to the demand. Similarly, only 235 012 PLWHA had been started on antiretroviral drugs (ARVs) out of 454 681 who are in need of the drugs.[389] Furthermore, the coverage of the prevention of mother to child transmission of HIV was about 78% as noted earlier.

My research findings revealed that my study area is surrounded with health facilities, which provide all the medical care related to HIV and AIDS. However, the majority of the population is reluctant to know their HIV status and to access the medical care available, irrespective of the ongoing HIV and AIDS awareness campaigns. Fortunately, the treatment of opportunistic diseases and the provision of antiretroviral therapy have

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[385] Weinreich and Benn, *AIDS – Meeting the Challenge*, p. 50.
[386] Gruskin and Maluwa, "Human Rights and HIV/AIDS," p. 643.
[387] Irin, "Country Profile: Tanzania – AIDS Pogrammes,"
<http://www.plusnews.org/pofiletreatment.aspx?Country=TZ&Region=EAF> 04/04/2008, p. 1.
[388] Avert, "HIV and AIDS in Tanzania," <http://www.avert.org/hiv-aids-tanzania.htm> Accessed: 10/11/2010, p. 1.
[389] UNAIDS, "United Republic of Tanzania – UNGASS 2010 Progress Reporting," p. 1.

saved lives. A number of people are healthy and involved in caring for and supporting their families in many ways. Since each individual has the right to life and the right to health, it is important for the government to prioritize health facilities by allocating adequate resources, so that all the citizens can benefit from these services. The presence of dehumanizing cultural practices in many societies in Tanzania deprive women and girls of their right to live and enjoy life as will be explored in the next section.

4.6.3.3 Failure to eradicate harmful cultural practices

While the National Policy on HIV and AIDS dictates that traditional and cultural practices which prevent individuals from negotiating for safer sex need to be addressed by all sectors,[390] this statement is too vague and too generalised because Tanzania has more than 130 ethnic groups and cultural practices are varied. For this reason, in daily life, the cultural practices which are harmful in the context of HIV and AIDS continue because the policy fails to specifically mention and challenge such harmful practices and to lay down strategies to address them.

Furthermore, the policy does not mention how the government will reach religious leaders or institutions that have strong influence over the people. As will be shown later church leaders are not gender sensitive as far as HIV and AIDS is concerned. Besides some of the religious teachings, especially the marriage liturgy as mentioned earlier, perpetuate the subordination of women to men, which is as detrimental to women's health in the context of HIV and AIDS, as the cultural practices are.[391] Such oppressive teachings are common in Africa, as noted by numerous scholars.[392] It is for this reason that the government ought to target religious leaders as influential community members who need to be well informed about the link between gender and HIV and AIDS and the way it impacts negatively on women, so that they may take the lead to educate their adherents on gender issues that fuel the transmission of HIV.

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[390] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 21.

[391] Mukangara and Koda, *Beyond Inequalities,* p. 39.

[392] Ezra Chitando, "Women," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy*, Geneva: WCC Publications, 2003, p. 188. See also Isabel Phiri, "Sermon Text Ruth 1-2," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy,* Geneva: WCC Publications, 2003, p. 192. Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 13, 14.

In addition, the laws and policies of the country do not protect the reproductive rights of women in Tanzania, reproduction being considered a cultural matter.[393] The Cairo Conference on Population and Development in 1994, and the Beijing World Conference on Women in 1995, both considered reproductive rights for women as human rights because of women's powerlessness in sexual relations.[394] Reproductive rights include the individual's right "to make decisions concerning reproduction, free of discrimination, coercion and violence."[395] A study of the reproductive rights of women in Tanzania found that these rights are not being met, due to the following reasons:

- Inadequate access to reproductive care and family planning;
- Severe restrictions on the ability of women to obtain an abortion even in the case of rape;
- Sexual violence against women and girls including rape, FGM and domestic violence;
- Unequal relations within the family leading to marital rape;
- Early marriages of girls;
- Inadequate access to sexual education. [396]

The above issues reveal in which ways women's reproductive rights are violated in Tanzania. The situation is exacerbated by the unfair social structure and the patriarchal attitude of males who dominate women's bodies and their sexuality, making them vulnerable to HIV infection. The Department of Health and Social Welfare have failed to respond adequately to this issue. In addition to women's vulnerability to HIV in terms of their reproductive rights, lack of access to equal education, employment and property ownership are aspects of injustice which contribute to the vulnerability of women to HIV infection which we will discussion next.

4.6.3.4 Denial of the right to equal education, employment and property inheritance

Although the national HIV and AIDS policy emphasizes the importance of equal opportunities in terms of education, leadership and access to production assets for both

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[393] Mascarenhas, *Gender Profile of Tanzania*, p. 44.
[394] Liesl Gerntholz, "Gender, human rights and HIV/AIDS," in AIDS Law Project, *Gender and HIV/AIDS: A Training Manual for Southern African Media and Communicators*, Johannesburg: AIDS Law Project, n.d p. 53.
[395] Mascarenhas, *Gender Profile of Tanzania*, p. 44.
[396] Mascarenhas, *Gender Profile of Tanzania*, p. 44.

men and women as an intervention to eliminate HIV and AIDS[397] - women are still in a disadvantaged position in this regard due to the fact that discriminative laws and policies remain in effective. These issues will now be discussed in turn.

4.6.3.4.1 Primary and Secondary education

During colonial times, only a few women attained formal education. After national independence, policies were laid out to ensure that free education for children and adults of both genders was in place in order to minimize the illiteracy rate which was still a reality for the majority of the citizens, as discussed at the beginning of this chapter. Primary education was made compulsory for every school-aged child but not all children benefited from this strategy for various reasons which will be underlined later in this section. This tremendous plan was in addition, disrupted by the re-introduction of school fees as part of the Structural Adjustment Programme (SAP) to cut down the public expenditure in all sectors including education.[398] Consequently, school enrolment dropped between the 1980s and 1990s. By the end of 1990, the enrolment was down to 54.2 percent in all levels, so that illiteracy rates increased for both males and females in Tanzania.[399]

Numerous interventional devices have been employed to redress the situation. One of those was the introduction of a programme known as Primary Education Development Programme (PEDP) in 2000, and the abolishment of school fees at primary school level in 2001.[400] These strategies facilitated the enrolment of school-girls to reach 90% against 91% for boys by 2004, compared with 58% in 1999. Despite this progress in enrolment, only 15 percent of primary school leavers are admitted to both public and private secondary schools, and the enrolment of girls in public schools is lower than that of boys, due to limited facilities being available for girls.[401] Another drawback is that the school performance of girls is low against that of boys at both primary and secondary levels.[402]

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[397] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 21.
[398] Mascarenhas, *Gender Profile of Tanzania,* p. 39.
[399] Mascarenhas, *Gender Profile of Tanzania*, p. 39.
[400] Mascarenhas, *Gender Profile of Tanzania*, p. 39.
[401] Mukangara and Koda, *Beyond Inequalities*, p. 42.
[402] Peasgood et al. (eds), *Gender and Primary Schooling in Tanzania*, p. xii. Mascarenhas, *Gender Profile of Tanzania*, p. 39.

Some of the reasons for their poor performance are poor teaching facilities, negative attitudes of teachers, male dominated education management, long distances to and from school, and the domestic work-load after school[403] which is associated with the traditional gender roles for women.

To redress the problem of lower performance rates by girls at the end of primary education (standard seven), the required academic performance to gain entry to public secondary schools has been set at a lower rate than that for boys, but the basic qualification requirements are still in place.[404] This affirmative action facilitated the increase of girls' enrolment. For instance, in 2003 their enrolment rose to 20 percent from 16 percent in the 1990s.[405] In 2006, female students who enrolled in Form 1 (the first year of secondary school) across the country amounted to 47.96 percent, whereas, males amounted to 52.04 percent of the total.[406] The gender imbalance at this level is minimal but at higher levels (Form V and VI) the enrolment of female students drops considerably partly because the majority of women do not measure up in science subjects as they lack encouragement from their teachers.[407] Many teachers consider girls to be less bright than boys and therefore unable to pursue science subjects. Although girls' performance has been generally lower than that of boys, there are some girls who have taken a lead in the recent results of national Form IV and VI examinations, which may indicate that girls are as capable as boys if they are provided with a conducive learning environment. For instance, girls' reached in Form VI examinations in 2008 a pass rate of 90.8% against their male counterparts 88.9%.[408] Congratulating the girls on their good performance, TAMWA stated that "the results had once again proved that girls in this country were indeed committed to achieving their ambitions through hard work."[409] TAMWA urged those who performed well to work harder at university level so as to join the ranks of

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[403] Peasgood et al. (eds), *Gender and Primary Schooling in Tanzania*, p. xii.
[404] Mascarenhas, *Gender Profile of Tanzania,* p. 39.
[405] Mascarenhas, *Gender Profile of Tanzania*, p. 39, 40.
[406] UNESCO, "Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015," <http://webapps01.un.org.nvp/frontend!gol.action?id=465> Accessed: 03/02/2010, p. 1.
[407] Mascarenhas, *Gender Profile of Tanzania,* p. 40.
[408] Guardian Reporter, "Tamwa hails girls' performance in Form 6 exams," <http://www.ippmedia.com/ipp/guardian/20008/05/113943.html> Accessed: 08/05/2008, p. 1.
[409] Guardian Reporter, "Tamwa hails girls' performance in Form six exams," p. 1.

educated women and take part in decision-making and general leadership positions in the country. It has been observed that women with higher education levels have greater autonomy over their reproductive health suffer less gender violence in intimate relationships.[410] It is therefore important to ensure that all barriers to women's access to education are eliminated, as it opens their way for liberation from marginalization and violence, which expose them to HIV.

Critical issues that serve as barriers to girls' achievement in primary and secondary education fall into four main categories.[411] The first group covers issues related to socio-cultural beliefs and practices which include early marriage and pregnancy as already mentioned previously. Pregnancy causes a girl to be expelled from school, and even the new Education Act established in September 1995 does not set up a legal right for pregnant girls to continue with their education.[412] This reveals the gender insensitivity of the policy makers and authorities responsible. That teenage pregnancies occur at a high rate indicates the practicing of unprotected sex, hence the girls are at risk of contracting HIV.[413]

The second category is associated with economic hardship. Although school fees have been abolished, parents are required to provide school uniforms, shoes, books and meals for their children. Some parents are unable to meet these costs, which make it difficult for children to complete their primary and secondary education especially, for the already mentioned reasons if they happen to be girls.[414] Gender biased socialization in school is the third obstacle to girls' completing their education. In this regard, self-confidence is promoted in boys, whereas girls are culturally and religiously encouraged to be submissive. Their poor performance at school and the above-mentioned hindrances contribute to the low enrolment of girls at institutions for tertiary levels of education which we will discuss now.

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[410] Mascarenhas, *Gender Profile of Tanzania*, p. 41.
[411] Unicef, "Girls' Education in Tanzania," p. 1.
[412] Peasgood, et al. (eds), *Gender and Primary Schooling in Tanzania*, p. xiii.
[413] Unicef, "Girls' Education in Tanzania," p. 1.
[414] Peasgood, et al. (eds), *Gender and Primary Schooling in Tanzania*, p. xii. See also Mascarenhas, *Gender Profile of Tanzania*, p. 40.

4.6.3.4.2 Tertiary education

The number of women who enrol for higher education is usually low, because few complete the high school level. To promote gender equity in government higher learning institutions - the University of Dar-es-Salaam, for example - the following measures have been taken as part of the policy that is applied to all tertiary education in East Africa.[415]

- A policy of admitting female direct entrance with lower cut-off points since 1977/78;
- Introduction, in 1997, of a six week pre-entry remedial programme for female students who have not attained the cut-off point, to boost intake of female students in the Faculty of Science;
- Provision of scholarships for undergraduate female students.[416]

These affirmative measures resulted in an increased number of admissions of undergraduate women-students at the University of Dar-es-Salaam. The number grew from 27 percent in 2001/02 to 38 percent in 2005/06.[417] A notable progress related to these admissions was that the number of women who enrolled in the Faculty of Science rose from 28 percent in 2001/02 to almost 40 percent in 2005/06. Nevertheless, the increase of female students at this university was not matched by the composition of female academic staff who accounted for only 17 percent in 2005/06.[418] The reasons for this gender gap among the staff might be attributed to the fact that only a few women have specialized in science subjects which are the main subjects offered at this university. Gender stereotyping in terms of employment opportunities in the sciences going to men rather than women could also be another factor which reinforces this difference.

Despite measures to close the gap, there is still much more to be done at primary and secondary school levels in order to achieve the gender parity in the level of higher education because this is a pathway to the attainment of higher positions and to gaining access to decision making bodies in all spheres of society. This has in turn been proven

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[415] Jane Onsongo, "Affirmative action, gender equity and university admissions – Kenya, Uganda and Tanzania," <http://www.informaworld.com/smpp/content-content=a909453790&db=all> Accessed: 03/02/2010, p.1.
[416] Mascarenhas, *Gender Profile of Tanzania*, p. 41.
[417] Mascarenhas, *Gender Profile of Tanzania*, p. 41.
[418] Mascarenhas, *Gender Profile of Tanzania*, p. 41.

to be a deterrent to the prevalence of HIV among women. Because the gendered nature of the pandemic and its means of transmission require a gender-sensitive approach, which is impossible to achieve without the involvement of women at decision-making level.

The persistence of social, cultural, religious and economic barriers that hinder girls and women from attaining equal education with their male counterparts shows that policy alone cannot solve the problem of access to educational opportunities for women. The social, cultural and religious factors need to be addressed in conjunction with the policies and this may be an area where the church can make a significant contribution. As with education, research has also shown that women who have higher education levels in society are in a better position to make informed decisions concerning their lives, and this has been identified as a major factor in halting the prevalence of HIV among women.[419] In the next section we will explore whether the government is succeeding in ensuring that women have leadership positions in society.

4.6.3.4.3 Women in formal employment/leadership positions

- *Public Service Management*

Sources of employment in the formal sector include those in the public service sector and in the private formal sector.[420] The employment positions in the government sector are fewer than those of the private sector because of the Structural Adjustment Programme policy as mentioned above. However, women are under-represented in both sectors. This is attributed to their lack of equal education as discussed above and to patriarchal domination, which is evident in all spheres of life in Tanzania. For instance, in September 2004, only 40 percent of the public servants were women.[421] The majority of them are in the lower cadre such as typists, telephone operators, library attendants, nurses and midwives. Women in senior government decision-making positions amount to only 24 percent of the total workforce. Various types of affirmative action have been laid out by the Public Services Management in the President's Office (PO-PSM) to address the gender gap in the public sector. One of these actions is that: "Where a man and a woman

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[419] Mascarenhas, *Gender Profile of Tanzania*, p. 41.
[420] Mascarenhas, *Gender Profile of Tanzania,* p. 26.
[421] Mascarenhas, *Gender Profile of Tanzania,* p. 28.

are equally competent, the job must be given to the woman."[422] Another action is the provision of scholarships for women to pursue postgraduate studies, which is intended to facilitate women's promotion to higher levels of employment in the government service. However, it is not yet known how far this action has been implemented because the Gender Unit in PO-PSM has not conducted any evaluation in relation to this policy. Despite these affirmative actions, gender inequalities and patriarchal relations remain evident in every level of the government.

- *The formal private sector*

The growth of the private sector has created additional opportunities for formal employment for women and men mainly in the urban areas. Despite the fact that few women are employed in this sector and that they are less skilled, women are indeed engaged in business enterprises and have formed a Business Women's Association.[423] Women employers in business enterprises are also relatively low compared to men. For instance, in 2005 there were only 38 female construction contractors/engineers out of a total of 3000 men.[424] Another disadvantage prevailing in this sector is the fact that the rights of workers are less stringently observed than in the government sector. The results of this include long working hours, low payment, summary dismissal and delays in payment in case of retrenchment. This situation forces the workers, both men and women, to adopt other mechanisms to supplement their low income. Women become overworked since they also have to carry out the daily domestic role. In addition, women are prone to sexual harassment in the course of searching for employment.[425]

- *Politics and decision making*

Despite the fact that Tanzania is signatory to many of the UN conventions and resolutions on gender equity, women are still currently poorly represented in decision making forums and leadership positions in all structures of the government. To address this gender imbalance, the parliament has introduced special seats for women, since the one party

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[422] Mascarenhas, *Gender Profile of Tanzania*, p. 28.
[423] Mascarenhas, *Gender Profile of Tanzania*, p. 29.
[424] Mascarenhas, *Gender Profile of Tanzania*, p. 29.
[425] Mascarenhas, *Gender Profile of Tanzania*, p. 29.

era.[426] One of the affirmative actions proposed by the Chama cha Mapinduzi (CCM)[427] was to accord women 15 percent of the seats in the National Assembly during the 1985 election.[428] Through the enactment of various laws, women's representation in the National Assembly has increased from 15 percent in 1985 to 20 percent in 2000, [429] to 25 percent in 2007/08.[430] In addition, some organisations led by women are identified and requested to send their representatives in this assembly, which then comprise the Special Women's seats. Through this strategy the total number of women in the National Assembly was 97 or 30.3 percent of 324 members in the last General Election (2005).[431]

Mascarenhas asserts that in December 2006 there were remarkable improvements in the representation of females at high political levels due to the appointment of females in key ministerial positions.[432] Generally, 27 percent of the cabinet of Ministers and Deputy Ministers were women, including six full Ministers and ten Deputy Ministers. The ministries of Finance, Foreign Affairs and International Cooperation, Education and Vocational Training, and Legal and Constitutional Affairs were headed by women for the first time since the country attained its independence in 1961.[433]

It is notable that the then Minister of Foreign Affairs and International Cooperation, Asha Rose Migiro was promoted in 2007 to be Deputy Secretary General in the United Nations, the highest position held by an African woman in the history of the UN.[434] Following this promotion, her ministerial post was filled by a male. Likewise, the women heading the other key ministries were replaced by males after President Kikwete dissolved the whole cabinet on February 8, 2008 following the resignation of the former

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[426] In 1977, the Tanganyika African National Union (TANU) which was the ruling party in Tanzania mainland merged with the Afro-Shirazi Party (ASP), a ruling party in Zanzibar, and formed the Chama cha Mapinduzi (CCM) which was the sole political party in the country until May 1992 when the government adopted a multi-party system.

[427] CCM is the current ruling party in Tanzania.

[428] Mascarenhas, *Gender Profile of Tanzania*, p. 67.

[429] Mascarenhas, *Gender Profile of Tanzania*, p. 68.

[430] United Nations, "Policies on gender, children's and women's affairs and their management and implementation strategies Tanzania, 2008," <http:webapps01.un.org/nvp/frontend!policy.action?id=503> Accessed: 03/02/2010, p. 1.

[431] Mascarenhas, *Gender Profile of Tanzania*, p. 68.

[432] Mascarenhas, *Gender Profile of Tanzania*, p. 68.

[433] Mascarenhas, *Gender Profile of Tanzania*, p. 3.

[434] Mascarenhas, *Gender Profile of Tanzania,* p. 4.

Prime Minister, Edward Lowassa.[435] The President reduced the number of Ministers from 61 to 47, a quarter of them being women. The then Minister for Justice and Constitutional Affairs, Hon. Mary Nagu (who was among the three female Ministers heading the key ministries) was later appointed as the Minister for Industry, Trade and Marketing while the rest were excluded from the new cabinet.[436] This new cabinet has only five women Ministers and five Deputy Ministers. This is to say that the representation of women in the cabinet is only 21 percent. The low representation of women in decision making forums is an indication that women are still discriminated against, despite the policies in place. The denial of women to inherit property is another injustice which has forced women to adopt risky behaviour as an alternative means for their survival, as will be discussed in the next section.

- *Denial of property ownership*

Although women form the majority (51.8 percent) of the population in the country according to the national census of 2002,[437] they are denied access to property ownership and associated decision making processes. The legal system in Tanzania is a three-tiered system consisting of customary, religious (mainly Islamic) and statutory law.[438] In this regard, issues related to inheritance or property ownership including land are governed by the customary laws, which violate human rights and discriminate against women.[439] This means that all gender policies from the government are subject to customary laws. Eighty percent (80%) of the communities in Tanzania are patrilineal and are hence guided by patriarchal construction.[440] Mukangara and Koda observe that:

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[435] Tanzanian Affairs, "President takes action – New cabinet," <http://www.tzaffairs.org/2008/05/president-takes-action-new-cabinet> Accessed; 15/02/2010, p. 1.
[436] Tanzanian Affairs, "President takes action – New cabinet," p. 3.
[437] 2002 Population and Housing Census Report, "2002 Regional Census results," p. 1. See also Rutazaa, "Tanzanian Women and Access to Law – The case of Kilimanjaro 2005," p. 4.
[438] Mascarenhas, *Gender Profile of Tanzania*, p. 61. Mukangara and Koda, *Beyond Inequalities*, p. 33.
[439] Mukangara and Koda, *Beyond Inequalities*, p. 33.
[440] Mukangara and Koda, *Beyond Inequalities,* p. 38. Peasgood, et al. (eds), *Gender and Primary Schooling in Tanzania*, p. 50.

> Under these customary laws women are denied control over clan and family property, income accrued from their labour, inheritance rights to matrimonial property and custody of children and property ownership after divorce or separation.[441]

Women are the main food producers (at 85%) utilizing the clan land either as single or married individuals but they have no right to own the land, and in most cases they are denied control over the agricultural product which their labour has produced.[442] In the case of the death of her husband, the widow has two options in some communities in Tanzania.[443] The first option is to be inherited by a male relative of the deceased husband. The second is to go back to her natal family after the bride price has been returned, particularly to those communities, which pay large sums of money or cows like the Kurya and Luo as mentioned earlier. In most cases, the children are taken away by the male relative of the deceased because they are claimed to belong to his clan, where they are often mistreated. This customary law reveals how women are treated like minors when it comes to their rights. However, recent studies have found that a number of widows are resisting being inherited, even at the cost of their rights to land and other property which they acquired during their marriage.[444] Through various income generating activities some have managed to supply their children with their basic needs. This has thus given these widows a higher degree of autonomy over their lives, which is also a way to protect themselves from HIV infection and abuse.

The Chagga law of inheritance is similar to that of many other ethnic groups in Tanzania since it is a partrilineal society. Traditionally, a Chagga woman or a girl cannot inherit the land or any other property owned by her father or husband because the land belongs to the clan. Inheritance, especially of the land and cattle goes to male children because they are the heirs.[445] If the family has no son (s), the land is given to a male relative of the man after the husband dies. The whole structure of inheritance governs the social system

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[441] Mukangara and Koda, *Beyond Inequalities*, p. 33.

[442] Peasgood et al. (eds), *Gender and Primary Schooling in Tanzania*, p. 50.

[443] Mascarenhas, *Gender Profile of Tanzania*, p. 55. See also Rutazaa, "Tanzanian Women and Access to Law," p. 19.

[444] Mascarenhas, *Gender Profile of Tanzania*, p. 56.

[445] Raum, *Chagga Childhood*, p. 137. Aginatha Rutazaa, "Tanzanian Women and Access to Law," p. 19.

whereby women have to depend on men for their survival. There are exceptional cases, in which a father may decide to give land to his daughter, but this is greeted with resistance from the clan, as explained by Magareth Shirima from Rombo district in Kilimanjaro:

> The family's clan will call a meeting to warn the "lost" father about taboos associated with such a decision. If the clan fails to convince the man, his sons will do what they can to get their sisters off "their land." For this reason we women cannot even accept a piece of land from our fathers because we know that the next step is to be killed.[446]

The quotation is clear about the discrimination against women concerning property ownership and once more it highlights how patriarchal ideology plays a significant role to ensure that women are regarded as unworthy to be treated as adult person.

The Village Land Act No. 5 of 1999 and the Land Act No. 4 of 1999 both enhanced gender equality as far as land and other property are concerned, but patriarchal customary laws surpass these laws, and hence deny women their right to equally access the land as their male counterparts do.[447] Nevertheless, some women have through recourse to these two legislations managed to purchase a piece of land away from the clan soil, which they use for residence or other productive purposes.[448] Culture has contributed to a great extent to the oppression of women and denial of their rights to resources. This is exacerbated by the lack of information on laws and by traditional customs, which deny their rights and dictate their lives. Gender activists working in NGOs such as Tanzania Women Lawyers Association (TWLA) are currently carrying out legal literacy education to conscientize the public. Legal clinics which provide counselling for women have been established but are mostly located in the urban areas.[449]

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[446] Magareth Shirima, "Women and Land Ownership," in Ruth Besha (ed), *African Women: Our Burdens and Struggles,* Johannesburg: Institute for African Alternatives, 1994, p. 32.

[447] Mascarenhas, *Gender Profile of Tanzania,* p. 62.

[448] Mukangara and Koda, *Beyond Inequalities*, p. 23.

[449] Mukangara and Koda, *Beyond Inequalities*, p. 33.

Women's denial of access to resources and assets such as land has forced a number of them to engage in sex work to earn their living. Referring to the situation of Bahaya women from Kagera region, Gabriel Rugalema asserts that:

> Women's lack of access to land meant that in the event of divorce a woman's livelihood would
> be threatened. In a place characterized by marital instability and a high rate of divorce,
> commercial sex was and probably remains almost the only alternative for often semi-literate
> women to support themselves and their children.[450]

Rugalema highlights only the divorced and those who might be involved in marital conflicts, but others who suffer the same fate include single mothers, widows, young women and those in low paid jobs who engage in risky sexual behaviour as their economic survival strategy. [451] The Bahaya women, as other women in Tanzania, spend their earnings from sex work to purchase land where possible, to educate their children and to support their elderly parents.[452] Concerning these gender issues in relation to HIV and AIDS, the National Policy on HIV/AIDS states that inheritance laws that prohibit women from owning property will be reviewed.[453] One wonders how long it will take the government to act on such crucial issues that have impoverished many women and that lead some of them to high risk behaviours as a means of survival. It is almost ten years since this statement was written but no action has been taken to date. Unfortunately, women continue to be at the receiving end of such delays due to the fact that the negative elements of culture continue to be maintained.

4.7 Conclusion

This chapter has provided a detailed historical and contemporary sketch of the context of HIV and AIDS in Tanzania. This was achieved through firstly providing a brief profile of Tanzania, secondly describing the situation of HIV and AIDS in the country, and thirdly

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[450] Gabriel Rugalema, "Understanding the African HIV Pandemic: An Appraisal of the Contexts and Lay Explanation of the HIV/AIDS Pandemic with Examples from Tanzania and Kenya," in Ezekiel Kalipeni et al. (eds), *HIV & AIDS in Africa: Beyond Epidemiology*, Oxford: Blackwell Publishing, 2004, p. 194.
[451] Mascarenhas, *Gender Profile of Tanzania*, p. 37. See also Mukangara and Koda, *Beyond Inequalities*, p. 30.
[452] Rugalema, "Understanding the African HIV Pandemic," p. 194.
[453] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 21.

through examining socio-economical and cultural determinants to the prevalence of HIV, namely poverty, migrant labour, female genital mutilation, early marriage and polygamy. Finally, the efficacy of the initiatives that the government has employed to curb the pandemic were also explored in detail. It was found that while several commendable policies and laws have been put in place, practically these are not implemented because of the domination of socio-cultural and religious practices and values, particularly in the area of gender. These issues then severely undermine such policies. In the next chapter, I will describe the HIV and AIDS programmes of the diocese, and I will evaluate whether and how they are addressing the socio-cultural and gender dynamics, which the programmes of the government have failed to do, as I have illustrated in this chapter.

CHAPTER FIVE

A GENDERED ANALYSIS OF THE HIV AND AIDS PROGRAMMES/POLICY OF THE ELCT NORTHERN DIOCESE

5.1 Introduction

The previous chapter set the context of the study. The situation of the HIV and AIDS pandemic in Tanzania was described. The chapter further highlighted the determinants of the pandemic and the national response to the pandemic, and illustrated that the response was inadequate in terms of the gendered approach that is needed with regard to the HIV and AIDS pandemic. This chapter aims to present the prevailing HIV and AIDS programmes and policy draft of the ELCT Northern Diocese. The central question the chapter attempts to answer is "What do the diocese's HIV and AIDS programmes/policy entail and how do these programmes address the gender dimensions which fuel the spread of HIV?" This chapter begins with a brief history of the inception of the HIV and AIDS programmes of the diocese, and thereafter analyzes these programmes, using the gender conceptualisation framework of HIV and AIDS programmes as developed by Rao Gupta.[454] The programmes are further analyzed using feminist theologies and African feminist cultural hermeneutics as pioneered by Kanyoro.[455] Hence this chapter addresses one of the central objectives of this study which is to assess whether and how the HIV and AIDS programmes of the diocese have responded to gender challenges that fuel the spread of HIV among its members. The data presented in this chapter has been gathered primarily from the forty-nine participants of my study, as mentioned and described in chapter three.

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[454] Rao Gupta, "Gender, Sexuality, and HIV/AIDS,"

[455] Kanyoro, *Introducing Feminist Cultural Hermeneutics*.

5.2 A brief history of the inception of HIV and AIDS programmes of the ELCT Northern Diocese

The inception of HIV and AIDS programmes within the diocese dates back to 20 November, 1991 when the Public Health Education Programme (PHEP)[456] director at the time, Dr. Janet Lefroy wrote to all parish leaders informing them about World AIDS Day[457] to be commemorated on 1 December, 1991 and which aimed at educating and reminding people of the impact of HIV and AIDS within societies.[458] She noted that the theme of that year's AIDS Day was "Sharing the Challenge" (*Kwa pamoja tuukabili UKIMWI)* and that since December 1st would fall on a Sunday; the parishes were urged to do the following to commemorate the day:

- To pray for persons living with HIV and AIDS and their immediate families;
- To read to the congregants the attached information.[459] (This information is presented in chapter one - it sketches the situation of HIV and AIDS in Tanzania and in particular, the Kilimanjaro region).
- To give an opportunity to parish public health committees or any other group within the parish to educate the congregants about the pandemic through a role playing exercise or through other possible means.[460]

She concluded her letter saying: "I believe that by God's grace we will be able to help society to overcome HIV and AIDS."[461] Lefroy's letter shows an awareness of what was

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[456]The Public Health Education Programme (PHEP) is one of the three units of the Department of Health and Social Service at diocese level. The others were diaconal and medical. Towards the end of 2005, the diaconal unit became a department due to the enormous challenges posed by HIV and AIDS within the diocese. The main task of the PHEP is to educate the communities on the importance of hygiene and nutrition, which started in 1972. Each parish has a PHEP committee whose responsibility is to select and supervise a group of grassroots parish health educators. The committee members are trained by a team of trainers from church health facilities, governmental and non-governmental organizations.

[457] World AIDS Day was first commemorated in 1988 and is organised by UNAIDS which chooses themes for each year. The focus of this day is to create awareness, improve education and fight injustice. In 2005, UNAIDS handed over this responsibility to "The World AIDS Campaign" (WAC) which is an independent organisation.

[458] Janet Lefroy, "Barua kwa viongozi wa sharika kuhusu Siku ya UKIMWI Duniani tarehe 1 Desemba 1991"- file DK/23/11/ 29, p. 1.

[459] This information highlighted the reality of the pandemic within the country with special focus on the Kilimanjaro region by 1990.

[460] Lefroy, "Barua kwa viongozi wa sharika kuhusu Siku ya UKIMWI Duniani," p. 1.

[461] Lefroy, "Barua kwa viongozi wa sharika kuhusu Siku ya UKIMWI Duniani," p. 1.

going on worldwide concerning the pandemic. It also served as a starting point for the congregants to be aware of and get involved in the struggle against HIV and AIDS.

In the following, the PHEP director, in a committee meeting held on 18/11/1992,[462] suggested the establishment of an HIV and AIDS programme. This suggestion resulted from the fact that the diocese has thus far not created any specific HIV and AIDS committee, apart from the existing PHEP committee.[463] The response from the assistant bishop who was then the chairperson of the committee was that: "the diocese is aware that the health committee is the HIV and AIDS committee."[464] This response assumed that HIV and AIDS was a health issue only, and this view point is why most of the programmes lack a gendered and a theological response. This assumption was also made by the Tanzanian government as we saw in the previous chapter who had formerly left the response of the pandemic to the Ministry of Health.[465] However, the progression of the pandemic forced the government to adopt a multi-faceted approach from 1992, as discussed in chapter four. Similarly, the background of the candidates who were selected to draw up the diocese's HIV and AIDS control programme, confirmed the above argument. Of the five nominees, four were health professionals, and only one was a pastor. The team included Dr. Janet Lefroy, the PHEP director, Sr. Aisa Makundi, the PHEP coordinator at the diocese level, and Dr. Ngoda who was the secretary of the diocese's Health and Social Welfare Department together with Rev. Daniel Lyatuu, the director of Clinical Pastoral Education (CPE) at the KCMC[466] Hospital and Sr. Margret Mshana, the former coordinator of the PHEP unit.[467] I have been unable to access any document related to their meetings that discussed a strategy to combat the pandemic.

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[462] The diocesan PHEP committee meets once or twice a year. In 1992 the committee met once in November.

[463] KKKT-DK, "Miniti za kikao cha kamati ya Elimu ya Afya ya Msingi tarehe 18/11/1992," file DK/23/11/ 29, p. 6.

[464] KKKT-DK, "Miniti za kikao cha kamati ya Elimu ya Afya ya Msingi," p. 6.

[465] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 3.

[466] KCMC is defined as Kilimanjaro Christian Medical Centre, a health centre owned by the national church (Evangelical Lutheran Church in Tanzania) with the auspices of the government. It is located in Moshi, 3 km from Moshi town. KCMC is one of the four referral hospitals in Tanzania, and the largest of all. Other hospitals include Muhimbili in Dar-es-Salaam, Bugando in Mwanza and Mbeya in Mbeya region which serves southern highlands.

[467] KKKT-DK, "Miniti ya kikao cha Elimu ya Afya ya Msingi," p. 7. I have sourced only a letter to Rev. Lyatuu to inform him on his appointment written on 13th January 1993. I assume that in case of Sr. Mshana, the PHEP staff communicated with her verbally since she was staying within the municipality.

Nevertheless, a strategy and programme emerged from these HIV and AIDS committee meetings, as will be discussed below.

On 30/8/1993, the PHEP director wrote to all PHEP parish chairpersons to inform them that the theme for the week of concentrated public health education scheduled for 11/10-17/10/1993 was "HIV and AIDS and the health of the community."[468] The PHEP chairpersons were asked to get the materials and posters for this theme from their circuit coordinators during their joint seminar where would be discussed how to facilitate and prepare those who would be involved in teaching in their parishes. The letter emphasised that congregants were to be divided into different groups according to their ages and genders, for example youth, women and men, to give them the opportunity to initiate free and open discussions. The Diocesan Health Week was organised for the first time in 1992; it usually takes place during the first week of September. Activities for the week are carried out by parish health education committees who undergo a prior seminar organised by their circuit coordinators.[469] Themes for each year are based on current social issues within the communities, and the materials are prepared by PHEP teams in the various circuits on a rotational basis.[470] For instance, the themes for 1992, 1994, 1995 and 1996 were: "Nutrition and health at all ages," "Alcohol and the health of the community," "Health and the environment," and "Health and development" respectively. Since HIV and AIDS became an issue of concern in 1993, the theme for that year was, "HIV and AIDS and the health of the community," as mentioned above, and it involved an appointed team and the circuit coordinators.

Various activities including public education are carried out on the week days from Monday to Saturday in the evenings, and on Sunday which is the climax of the week. In addition to presenting the summary and conclusion of the discussions on the theme, the parish health education committee presents a report on the activities of the PHEP committee for the year and the achievements or weaknesses thereof. The Sunday is also

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[468] Lefroy, "Barua kwa wenyeviti wa Elimu ya Afya ya Msingi kuhusu wiki la Afya tarehe 11-17/10/1993," file DK 23/11/29, p. 1.
[469] Lefroy, "The History of the Public Health Education Programme 1997," p. 2.
[470] Lefroy, "The History of the Public Health Education Programme," p. 2.

marked by an offering to support the PHEP at the diocese level. The first time the diocese carried out the HIV and AIDS week it took place in October instead of September which is the agreed-upon period for health activities. I assume that there was a clash with another diocese programme. This particular HIV and AIDS week campaign was the starting point of HIV and AIDS education awareness within the diocese, and focused on prevention and behavioural change as will be discussed in detail in the next section. The second diocesan HIV and AIDS week was convened in 2003 around the theme "HIV and AIDS is a disaster."[471] It focussed on the continuing devastation of the pandemic within the communities. After this brief introduction to the background, I can now turn to the responses to questions with regard to diocesan HIV and AIDS programmes.

5.3 A gender analysis of the HIV and AIDS programmes/policy of the ELCT Northern Diocese

The ELCT Northern Diocese has eight HIV and AIDS programmes which are as follows:

1. HIV and AIDS education awareness
2. Voluntary counselling and testing (VCT)
3. Antiretroviral drugs (ARVs)
4. Prevention of mother-to-child transmission (PMTCT) of HIV
5. Physical and spiritual care-giving
6. Support groups for HIV positive people
7. Income generating projects
8. Provision of social support to orphans

In the rest of this chapter I will analyze whether and to what extent each of these programmes show an awareness of gender and the way in which it is related to HIV and AIDS.

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[471] KKKT DK/ Elimu ya Afya ya Msingi, "UKIMWI ni Janga -Somo la Wiki ya Afya 17-25 Agosti 2003," p. 1.

5.3.1 HIV and AIDS education awareness

Among the eight HIV and AIDS programmes of the diocese, HIV and AIDS education awareness is considered to be the leading programme. The provision of HIV and AIDS education is carried out by the PHEP team, consisting of diocese and circuit coordinators, zonal educators and parish educators as indicated by the respondents. Health professionals from church and government health facilities and non-government organisations are invited as guest speakers during HIV and AIDS seminars held in the parishes or schools.[472] The respondents also stated that this education is offered to all categories of people ranging from school children from standard five onwards (10 years and above),[473] the confirmands, youth and adults. The methods commonly used in teaching include lectures, video tapes, role play, discussion and testimonies from PLWHA. PHEP coordinators and zonal educators noted that there are special tapes available for teaching children about HIV and AIDS, such as "*Watoto wa Karati*" (street children). Various HIV and AIDS video tapes which are used in the seminars are available at the PHEP diocese office. The PHEP 1997 annual report which is compiled from the reports from each circuit indicates that the PHEP team had managed to visit most of the primary and secondary schools, church hospitals/health centres, and parishes to educate the masses about HIV and AIDS.[474] This report asserts that the targeted groups at health facilities were out-patients and families who have sick relatives at the centres. Commenting on the progress of the HIV and AIDS education within the diocese in 1998, the PHEP director said:

> Seminars on HIV and AIDS prevention for school children, youth and other groups in the parishes are still in demand…The school students enjoyed the course very much and appreciated the open discussions, saying that they are now aware and will be more careful.[475]

The statements affirm the validity of the initiatives of the PHEP team. Response from the recipients are positive, in particular those from the learners who are the future generation

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[472] PHEP unit works in collaboration with other HIV and AIDS government agencies and non-government organizations within the region as will be discussed later in this chapter.

[473] The school children from standard five onward are said to be able to understand what they are taught concerning the topic.

[474] KKKT-DK, "Taarifa ya Elimu ya Afya ya Msingi Mwaka 1997," p. 6, 7, 8, 9.

[475] KKKT-DK, "Taarifa ya Elimu ya Afya ya Msingi Mwaka 1998," p. 7.

that needs to be protected from HIV infection. As part of this programme, a handbook for Religious Education teachers about HIV and AIDS called "*Maisha ya Ushindi*" (Victory Life) was prepared by PHEP in collaboration with staff from the KCMC hospital, and KIWAKKUKI,[476] using material from the Scripture Union Zimbabwe.[477]

It is noteworthy that apart from the HIV and AIDS seminars and the teachings offered by the PHEP team, the Women and Youth Departments also prioritized HIV and AIDS education in their forums. For instance, during the annual Easter Conference (in March or April), which brings together youth from secondary schools and parishes as well as during the "Week of Youth and Bishop" in September mainly for youth from the parishes, HIV and AIDS awareness is among the topics highlighted (PM-2 on 23/02/2007). Around 10 000 youth attend these meetings each year.[478] This number is minimal, due to the limited accommodation facilities which have always been a challenge to the diocese.

Similarly, in the Women Department during its annual meetings with parish-workers[479] and women leaders at diocese and circuit levels, also emphasized HIV and AIDS education since women shoulder the burden of the pandemic in a variety of ways, including care giving to sick members of their family and of society at large, as well as to orphans (PM-3 on 26/02/2007). Besides caring for the sick, women are also victims of the pandemic. For these reasons, the department in collaboration with KIWAKKUKI organised a four day workshop for parish-workers on the subject of HIV prevention in June 2002.[480] After the workshop, participants were required to go back to their communities to impart the obtained knowledge to their church members. The feedback indicated that 14, 274 congregants were reached during Sunday services among various

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[476] KIWAKKUKI is a Swahili acronym for *Kikundi cha Wanawake Kilimanjaro Kupambana na UKIMWI* (Kilimanjaro Women Vigorously Fighting Against HIV and AIDS).
[477] KKKT-DK, "Taarifa ya Elimu ya Afya ya Msingi Mwaka 1998," p. 7.
[478] Burkhardt, "Mpango mkuu wa KKKT-DK kupambana na UKIMWI na kusaidia Yatima," p. 5.
[479] Parish-workers are female full-time parish personnel trained in Bible schools whose main tasks revolve around the youth and women's activities in their parishes. They also teach Religious Education in the schools, Sunday school and confirmands, and conduct home visits like other parish staff.
[480] KKKT-DK, "Mkutano Mkuu wa 28 wa Dayosisi, Masoka, 6-10 Desemba, 2003," p. 20.

groups within the parishes, including widows and PLWHA, as well as in schools.[481] In addition, between 2005 and 2006, seminars on stigma reduction were held for all parish women leaders as a strategy to eradicate stigma within communities. These leaders were obliged to disseminate this knowledge to their respective parishes.[482]

Although HIV and AIDS education awareness has been used as the major strategy in responding to the pandemic, Kilimanjaro region had the fifth highest rate of HIV infection in the country in 2006.[483] Fortunately, this rate has decreased to 1.9 % by the end of 2008,[484] so that the area is now among the four regions with the lowest rates of infection (less than 2 percent).[485] Imparting HIV and AIDS knowledge to the general public was the approach employed by the government when the NACP drew up the first Medium Term Plan (1987-1991) to address the pandemic as discussed in chapter four. Why HIV and AIDS knowledge ought to be imparted to the populace is clearly stated by Alta van Dyk who argues:

> The purpose of HIV/AIDS education is not only to disseminate information, but also to change attitudes and behaviour, to equip people with necessary life skills, to empower them to prevent the spread of HIV infection and to care for people who are already infected.[486]

This argument outlines the wide range of knowledge which is necessary to help people to change their risky life styles and to provide them with skills to protect themselves from HIV infection. It also notes the importance of caring for infected persons which is one way of countering stigmatization and containing the pandemic.

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[481] KKKT-DK, "Mkutano Mkuu wa 28 wa Dayosisi," p. 20.

[482] Burkhardt, "Mpango mkuu wa KKKT-DK Kupambana na UKIMWI na kusaidia Yatima," p. 5.

[483] KKKT-DK, "Mkutano Mkuu wa Elimu ya Afya ya Msingi: Taarifa ya Mwaka 2005," p. 3. See also "Taarifa ya Dayosisi kwa Mkutano Mkuu wa 29- Masoka 24-29 Juni, 2006," p. 12.

[484] See Appendix 11 which shows the latest HIV prevalence for each region in Tanzania.

[485] TACAIDS, "2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey," <http://www.ihi.or.tz/docs/TzHIV-MalariaIndicatorsurvey-07-8-PreliminaryReport.pdf>Accessed: 20/04/2010, p. 1.

[486] Alta van Dyk, *HIV/AIDS Care & Counselling: A Multidisciplinary Approach,* 2nd edition, Cape Town: Pearson Education South Africa, 2001, p. 92.

Given that the programme of the PHEP on HIV and AIDS education awareness has been taken up by both the youth and the women, it is clear that the need for the HIV and AIDS education programme has been taken seriously by the diocese. The question remains how gender sensitive the content of the HIV and AIDS awareness education programme is? In this regard, I posed a question to both the educators and the recipients of the HIV and AIDS education programme regarding the content of the programme. This question required the respondents to list and to discuss the content of the different components of the HIV and AIDS education programme. The majority of the respondents identified the following issues:

- How HIV is transmitted
- Prevention of HIV infection
- Care for people sick of HIV and AIDS related illnesses
- Nutrition for PLWHA
- Stigma eradication
- Support groups for PLWHA
- Sexually transmitted diseases
- Voluntary counselling and testing (VCT)
- Opportunistic infection and its management
- HIV and AIDS symptoms
- Antiretroviral therapy/Proper intake of the drugs (ARVs)
- Income generating projects
- To live with hope
- To join the saving and Credit Cooperative Society (SACCOS)

Significantly, what was missing in their identification of the content of the HIV and AIDS awareness education programme was a discussion of how gender dynamics play a role in each of the above issues. The respondents were able to articulate knowledge of only the basic medical facts about HIV and its treatment and medication, but could not go into any detail about the social and cultural factors which fuel the spread of HIV.

Furthermore, the respondents also noted that the HIV and AIDS awareness programme was not gender sensitive. For example, four male respondents pointed out that education on equality between men and women is vital in responding to gender factors that fuel the spread of HIV. One of the PLWHA said:

> Parishioners need to be educated about equal rights between men and women for the sake of eradicating patriarchy that denies women to have control over their bodies (PLWHA-6 on 4/02/2007).

This response mirrors the discussion in previous chapters about the impact of the patriarchal system on the lives of women, since men dominate in the sexual arena which puts women at risk of being infected. This awareness, though mentioned by only a few of the respondents, offers a starting point for the dismantling patriarchal gender constructions. However, such an undertaking can only be effective if policy makers and those who construct the curriculum of the HIV and AIDS awareness programmes are themselves educated about gender dynamics (as one of the respondents suggested), and thereafter impart the knowledge to their communities. It was with this in mind that one respondent suggested that it is vital to develop gender awareness among the church leaders and policy makers. He said:

> To ask how the church can curb gender factors that contribute to the spread of HIV is meaningless because church leaders are not aware of gender in its broad sense. So the first step is to educate the church leaders (who are mainly pastors) about gender and its link to the pandemic, who would then educate their members (ZE-13 on 21/02/2007).

This argument is crucial because it highlights that to undermine the patriarchal constructions may not be welcomed or may take a long time to be implemented since authority remains in the hands of men who are leading their families and the church in general.

Another area that was significantly missing in terms of gender sensitivity in the programmes is that of peer education. As discussed earlier, HIV and AIDS education is

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carried out by the PHEP team in collaboration with professionals from church health facilities, government and NGOs who are male and female adults. Though these educators are adults, they are of different ages and they have to impart their relevant knowledge to congregants who are also of different ages and genders. Rao Gupta recommends the Stepping Stones programme as a peer group programme that may cater for the difference in ages and genders among groups.[487] The reasoning behind peer education groups is that of the sensitivity of the subject, and the fact that HIV and AIDS is related to sex and sexuality, might hinder open discussion on the reality of the pandemic. Therefore, the training of peer educators across age and gender groups is essential for the effective dissemination of HIV and AIDS knowledge to congregants of all ages and genders, as has been demonstrated by the Stepping Stones programme. The World Council of Churches (WCC) has also highlighted peer groups as one of the essential elements in providing information and education about HIV and AIDS. It states:

> Peer groups - persons from the same age range who are acquainted with the social and cultural environment of the targeted groups – are much more effective in education than people coming from "outside." [488]

Similarly Van Dyk commenting on the significance of peer support argues:

> Behaviour change is mostly likely to occur if peers educate and support each other. Youth programmes that are run by youth…are all extremely effective in promoting practices and behaviour leading to reduction of HIV transmission.[489]

Given that several bodies and scholars have argued for the need for peer groups, both in terms of age and gender in HIV and AIDS awareness programmes, it is notable that peer

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[487] Stepping Stones is a programme directed at improving gender parity, sexual and reproductive health through community participation, relationship skills, awareness creation of the effects of risk-taking behaviour and decision-making at local level. The programme is designed in such a way that people of the same age and gender work together in order to create a non-threatening environment and encourage more open discussions on taboo topics such as sexual health, drugs and alcohol, relationship issues, and gender relations. Source: "What is the Stepping Stones Programme? <http://www.fspi.org/fj/index.php/stepping-stones.html>Accessed: 09/07/2010, p. 1.

[488] A WCC Study Document, *Facing AIDS*, p. 11.

[489] Van Dyk, *HIV/AIDS Care and Counselling*, p. 93.

groups, based on age and gender, are missing in the HIV and AIDS awareness programmes of the diocese.

Finally, the Abstain and Be Faithful (AB) strategy employed by the diocese can be labelled as a gender-neutral programme according to Rao Gupta. The main focus on HIV and AIDS education awareness with regard to HIV prevention in the programme of the diocese is based on abstinence for young people and faithfulness among couples. The diocese's HIV and AIDS draft policy states:

> The ELCT-ND will fully promote the Abstinence and Be faithful strategy which is in compliance with the Christian concept that sexual intercourse is reserved for married couples only. To have sexual relationships outside marriage is adultery and fornication.[490]

According to Rao Gupta, using the ABC strategy is an example of a gender-neutral programme because it assumes that A, B and C operate in the same ways for both women and men. Firstly, the church does not even enter into dialogue about condom use, an aspect which is completely missing from the programme. Secondly, the educational programmes on faithfulness ignore extra marital relationships and intergenerational sexual practices among Chagga men. This is despite research which has shown that the majority of women who are infected are the ones who are married and faithful to their husbands.[491] Furthermore, the fact is ignored that married women in particular are powerless in protecting themselves, because they are by their society expected to respect their husbands at all costs without questioning possible risky behaviour. In such cases, the strategy of abstinence is not appropriate for women because sexual relations in marriage are considered as the duty of women and a right of men.[492] In addition, Rao Gupta points out that the existence of sexual violence against women, puts them at great risk and makes abstinence into an irrelevant strategy for single women who are exposed to such forms of violence. It is for this reason that Rao Gupta argues that the ABC

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[490] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 11.
[491] Dube, "Grant Me Justice," p. 9. See also Commonwealth Secretariat, *Gender Mainstreaming in HIV/AIDS*, p. 26.
[492] Nicolson, *AIDS: A Christian Response*, p. 21. See also Nicolson, *God in AIDS?* p. 231.

education, which the diocese is using in their programmes (without the C) is more harmful than helpful for women if employed in a gender-neutral way.

From the above, it is clear that whilst the participants noted the importance of the HIV and AIDS awareness programmes which disseminates facts to the congregants about various important relevant issues, my analysis has shown that the programme on HIV and AIDS awareness is deficient in at least two areas with regard to gender. In the next section, I will undertake a gendered analysis of three other programmes of the diocese which offer clinical services. These are voluntary counselling and testing (VCT), prevention of mother-to-child transmission of HIV (PMTCT), and the provision of antiretroviral drugs (ARVs).

5.3.2 Voluntary counselling and testing/ARVs/PMTCT

The voluntary counselling and testing (VCT), prevention of mother-to-child transmission of HIV (PMTCT), and the provision of antiretroviral drugs (ARVs) for PLWHA are the clinical services that fall under the HIV and AIDS programmes of the diocese. The existence of these services and their efficacy in terms of gender will now be discussed.

5.3.2.1 Voluntary counselling and testing (VCT)

A voluntary counselling and testing service was introduced in Tanzania in 1989.[493] The long incubation period of HIV requires individuals to be tested since this is the only way in which a person can get to know his or her HIV status. The development of AIDS in an HIV infected person has been given different time frames by different scholars. Some indicate 10 years,[494] others between 5 and 15 years,[495] while 25 years is the longest time span.[496] The HIV test is therefore crucial. Although VCT is still perceived by many as a 'death

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[493] TACAIDS, "Voluntary Counselling and Testing (VCT)," <http://www.tacaids.go.tz/index.php/thematic-ares/prevention/116-voluntary-couseli...>Accessed: 23/05/2009, p. 1.

[494] Nicolson, *AIDS: A Christian Response*, p. 9. See also, Clive Evian, *Primary AIDS Care: a practical* guide *for primary health care personnel in the clinical and supportive care of people with HIV/AIDS,* Johannesburg: Jacana, 1993, p. 231.

[495] Usdin, *The No-Nonsense guide to HIV/AIDS*, p. 70.

[496] Caroline Carlisle, "HIV and AIDS" in Tom Mason at el. (eds), *Stigma and Social Exclusion in Healthcare*, London: Routledge, 2001, p. 120.

sentence,' due to the stigma attached to the pandemic,[497] it has also been noted that there is a high demand for this service across the country[498] where only a few VCT sites have been established. For instance, between 2002 and 2004 the country had only 527 VCT sites with 1201 trained counsellors.[499] By the end of April 2009, VCT centres had increased to 2 134 as mentioned earlier. These centres which are established mainly in the urban and referral hospitals do not cater for the majority of the Tanzanians who are living in the rural areas. Although the country is in financial crisis, comprehensive strategies need to be initiated to expand this essential service to the entire population. Public, private and religious hospitals offer this service, including the ELCT Northern Diocese hospitals which began to offer VCT in 2004. Individuals were required to pay 1 000 Tanzanian Shillings[500] as a fee for this service (which is equivalent to 0.67 U$D) until mid 2007 when it became nationally sponsored.[501] Addressing the public during the launch of a nationwide testing campaign on 14/07/2007, President Jakaya Kikwete who set an example by being tested together with his wife said: "It is possible to attain a zero HIV prevalence rate if people volunteer to know their health status."[502] The President's argument affirms that it is only through an HIV test that a person can know his or her status, and therefore take all the necessary precautions so as to avoid infection or infecting others.

The respondents explained that given the fact that HIV and AIDS is a new pandemic, all those involved in HIV and AIDS work (PHEP team members) had needed to attend various counselling training courses offered by the government, NGOs and the PHEP unit to equip them with counselling skills. Indicating the importance of counselling, one of the zonal educators who is also a health worker said:

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[497] The United Republic of Tanzania, *National HIV/AIDS Communication and Advocacy Strategy*, May 2006, p. 11.
[498] TACAIDS, "Follow-up to the Declaration of Commitment of HIV/AIDS (UNGASS)," <http://data.unaids.org/pub/report2006/2006_country_progress_report_tanzania_en.pdf > Accessed: 23/05/2009, p. 12.
[499] TACAIDS, "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)," p. 12.
[500] USAID/AMREF, "ANGAZA: Wataalam wa Ushauri Nasaha na Kupima," ANGAZA Informational Brochure, p. 2.
[501] PlusNews, "Tanzania: Government to set up ARV rollout and VCT," <http://plusnews.irinnews.org/Report.aspx?reportId=73298> Accessed: 04/08/2007. p.1.
[502] PlusNews, "Tanzania: Government to step up ARV rollout and VCT," p. 1.

We offer pre-and-post counselling to facilitate voluntary HIV testing so that individuals are prepared to come to terms with the test results. Those who are diagnosed to be positive are treated either in public or church clinics/hospitals that are closer to their residence. We make a follow up to ensure that they attend the clinics and also take their medication as prescribed (CD-4 on 23/01/2007).

Gender statistics of individuals who visited two of the diocesan's hospitals for VCT are illustrated in the tables below.

Table 1: VCT Machame Hospital 2004-07

Year	No. of Males	HIV+ Males	No. of females	HIV+ females
2004	206	6	141	9
2005	314	16	284	22
2006	670	14	865	53
2007	762	22	810	51
Total	1952	58	2100	135

Source: VCT – Angaza, Machame Hospital Records, 2008.

Table 2: VCT Marangu Hospital 2004-07

Year	No. of Males	HIV+ Males	No. of females	HIV+ females
2004	435	19	398	43
2005	759	46	721	64
2006	658	47	1090	139
2007	880	42	1060	132
Total	2297	135	2871	335

Source: VCT –Angaza, Marangu Hospital Records, 2008.

An analysis of the two tables based on gender reveals that every year there is an increase in the number of those who volunteered to be tested as well as an increase in the incidence of HIV infection for both genders. However the increase among women is higher even though the numbers of men and women accessing the service are not equal. The question is: why are there more women than men, who are undergoing tests and who turn out to be HIV positive? On the one hand the best response to this question is taken from one of the female coordinators who is also one of the respondents. She stated that usually women feel obliged to take an HIV test because they are aware of the risky behaviour of their husbands (CD-3 on 05/03/07). In addition, according to Rao Gupta[503] and other researchers [504] it is because of the subordination of women to men that more women are vulnerable to HIV infection. On the other hand although the tables show that more women than men are infected with the virus, UNAIDS has shown that more men are reluctant to seek treatment timeously, due to the ideology of masculinity that requires that they appear to be brave at all times,[505] hence leading to the above mentioned statistics with regard to HIV testing. Men's delay in accessing test and treatment results in the progression of the virus which then causes illness and premature death.

The second gendered aspect of the VCT service is connected to married couples. The issue here is whether one partner can access VCT with or without the knowledge of the other. The majority of the implementers of the HIV programmes of the diocese indicated that a man or a woman is free to take the HIV test with or without prior consultation with their spouses. However, if a partner is diagnosed to be HIV positive, they counselled the person by showing them the importance of informing the other partner so that both can be tested and treated. Nevertheless, no one can be forced to disclose their status as one of the respondents said:

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[503]Rao Gupta, "Gender, Sexuality, and HIV/AIDS," p. 2.
[504] Nicolson, *AIDS: A Christian Response*, p. 47. See also Nicolson, *God in AIDS?* p. 224, 225. Patricia Siplon, "AIDS and Patriarchy: Ideological Obstacles to Effective Policy Making," in Amy .S. Patterson (ed), *The African State and the AIDS Crisis*, Aldershot: ASHGATE, 2005, p. 23. Usdin, *The No-Nonsense guide to HIV/AIDS,* p. 47.
[505] UNAIDS, "Men and AIDS: A gendered Approach - 2000 World AIDS Campaign," <http://data.unaids.org.pub/report/2000/20000622_wac_men_en.pdf> Accessed: 19/07/2010, p. 3.

if they refuse, we don't force them; rather we treat them according to their stages of infection, whether it is [an] opportunistic infection or [whether they] require ARVs (CD-4 on 23/01/2007).

This respondent said that health workers are governed by the National Policy on HIV and AIDS which urges medical practitioners to maintain confidentiality concerning HIV testing and results for their clients. The policy on HIV testing forbids health providers to disclose someone's HIV status to a third person without their consent, even if it is their spouse.[506] The refusal to disclose their HIV positive status to their partners has been observed to occur among both males and females. However, women are particularly fearful due to the violence or rejection they may encounter from their husbands (CD-4 on 23/01/2007 & ZE-8 on 30/01/2007). Although there is a tendency of both men and women to refuse to reveal their HIV positive status to their spouses, the reluctance of women is based on their subordinate position in society since the disclosure can result in violence or rejection as had been indicated by research conducted in other parts of the country.[507] The respondents made it clear that those who refuse to inform their partners about their HIV status but continue to take their medication secretly, present a risk for both partners as they continue with unprotected sex, but indicated that this is beyond their control as it is a private affair.

However, those who test positive and agree to tell their partners are asked to come together with those partners to the clinic, and after thorough counselling the latter are informed and advised to be tested too. If both are infected then both are treated and advised to use preventive measures. If only one is infected, they are also advised to use preventive measures to safeguard the other from infection. For married couples who are both infected or of whom one is infected, male and female condoms are provided as treatment to minimize re-infection (CD-4 on 23/01/2007, ZE-8 on 30/01/2007 & CD-3 on 05/03/2007). This is the only circumstance under which the programme of the diocese advises the use of condoms. The above response agrees with the clarification of the ELCT Managed Health Care Programme personnel who were interviewed by Paul Isaak in 2003. The personnel spelled out that condoms in church related health facilities are administered to married couples as a medical device in relation to HIV infection, after the infection of one or both

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[506] The United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 24.
[507] Usdin, *The No-Nonsense guide to HIV/AIDS*, p. 55.

partners,[508] and not as a prevention method. No condoms are given to unmarried people who are diagnosed to be HIV positive in the church related hospitals, since this is viewed as promoting immorality (CD-4 on 23/01/2007).

Thus, in this section, I have demonstrated two things: first, men and women have equal access to the service of VCT, although increasingly more women than men are going for testing. Hence, as I have indicated earlier, the women are becoming more aware that they are at risk from partners who are unfaithful even if they themselves are faithful. Second, both men and women are encouraged to disclose the results of their HIV status to each other. However, both men and women are reluctant to do so for gendered reasons as explained above. Therefore, this shows that while the VCT programme is important, the gendered factors, such as violence and masculinity need to be taken into consideration. Next, we look at the second clinical service programme offered by the diocese namely ARV's.

5.3.2.2 Antiretroviral therapy (ARVs or ART)

The provision of antiretroviral drugs (ARVs) is another service that is offered by the diocese's health centres to persons who have reached a stage that requires this regime. The establishment of a national care and treatment plan by the Tanzanian government between 2003 and 2008[509] was geared to the roll-out of antiretroviral drugs to its citizens free of charge with effect from 2004 via state facilities. This service was also extended to some private and religious health facilities. As mentioned in chapter four, the three hospitals run by the diocese have been recipients of these drugs since 2006. The HIV and AIDS draft policy states that the diocese will ensure that all treatment related to the HIV and AIDS will also be available and accessible in its 25 dispensaries which fall under the diocese's hospitals.[510]

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[508] Paul Isaak, "A Biblical and Ethical Response to HIV/AIDS," in *Africa Theological Journal*, 27, 1, (2004), p. 70.
[509] TACAIDS, *National HIV/AIDS Communication and Advocacy Strategy*, (May 2006), p. 14.
[510] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 9.

The PHEP team has the responsibility to monitor whether persons are taking their drugs regularly since incorrect intake will bring about the further deterioration of their health. Below is a table of gendered statistics of those on antiretroviral therapy in both Machame and Marangu Hospitals.

Table 3: Individuals on ARVs at Machame Hospital 2006-08

Year	No. of males	No. of females
2006/07	116	226
2007/08	123	242

Source: Care and Treatment Clinic (CTC) Records at Machame Hospital, 2009.

Table 4: Individuals on ARVs at Marangu Hospital 2006-08

Year	No. of males	No. of females
2006/07	13	17
2007/08	88	197

Source: Care and Treatment Care Clinic (CTC) Records at Marangu Hospital, 2009.

Generally, the above tables for both centres show that more women than men access treatment services. This is accounted for by the increase in number of those who have been visiting HIV testing centres operated by the church as indicated in the tables 1 and 2 above. There is a correlation between going for testing and going for treatment among men and women. If one goes for testing is almost inevitable that one will seek treatment afterward if needed. Therefore, because more men are reluctant to be tested due to their socially constructed masculinity which pressurizes them not to show that they are "weak" as shown above, therefore it is therefore logical that they will not want to access

treatment for the same reasons. Similarly, we have noted that more women go for testing and it is therefore logical that more women are on life-saving medication.

The prevention of mother-to-child transmission of HIV which is the third clinical service offered by the diocese's health centres, will be explored in the next section.

5.3.2.3 Prevention of mother-to-child transmission of HIV

The programme dealing with the prevention of mother-to-child transmission (PMTCT) of HIV was initiated by the government in 2000 due to the fact that the majority of children who are HIV positive are infected with HIV through mother-to-child transmission (MTCT).[511] The limited budget allocated for health facilities has hampered the wide geographic spread of PMTCT sites as is the case for VCT and ARVs, hence the majority of women in need of this crucial service are unable to access it. As stated earlier, the national coverage of this service is about 78 percent. Fortunately, the diocese's hospitals are among the sites that have offered PMTCT service since mid 2006 as demonstrated in the tables below which indicate the number of HIV+ women, who receive PMTCT treatment to protect their children.

Table 5: PMTCT Machame Hospital 2006-08

Year	No. of pregnant women	HIV+ women
2006/07	393	9
2007/08	234	6

Source: PMTCT Records at Machame Hospital, 2009.

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[511] M. B. Lyatuu, G. I. Msamanga, & A. K. Kalinga, "Clients' satisfaction with services for Prevention of Mother-to-Child Transmission of HIV in Dodoma Rural District," in *East African Journal of Public Health*, 5, 3, 2008, p. 174. See also A. Schwarendruber and G. Msamanga, "2002 TNZ: Evaluation of the UNICEF-sponsored Prevention of Mother-to-Child transmission (PMTCT) Pilot Project in Tanzania," <http://www.unicef.org/evaldatabase/index_31132.html>Accessed: 19/05/2009, p. 1.

Table 6: PMTCT Marangu Hospital 2006-08

Year	No. of pregnant women	HIV+ women
2006/07	246	8
2007/08	350	25

Source: PMTCT Records at Marangu Hospital, 2009.

With regard to the above tables, since the PMTCT service deals directly with the already infected mothers, I inquired from HIV and AIDS educators what the efforts are made to ensure that both partners are well informed about the situation they face and its consequences. The common response was that men (husbands) have been encouraged to attend clinics with their HIV positive wives but this campaign has never been successful because of the non-cooperation of some men. The men need to be present at PMTCT clinics to learn how to have safer sex during pregnancy to prevent the infection of the unborn and newborn. However, as we have seen above, masculinity plays a significant role in determining how men respond to the pandemic. Thus, in traditional Chagga society pregnancy and childbirth are considered to be women's issues, and it is not culturally acceptable from men to become involved in this aspect of life.

Therefore, HIV and AIDS awareness programmes need to deal with issues of gender, in order for treatment programmes such as VCT, PMTCT and ART to be effective. Having dealt with the clinical treatment programmes of the diocese, I now turn my attention to the programme which deals with care, in order to analyze this programme from a gender perspective.

5.3.3 Physical and spiritual care for PLWHA

The huge impact of HIV and AIDS related illnesses on health facilities has stretched them beyond their capacity and this has resulted in the emergence of home-based care whereby the sick and dying are cared for by their family members or relatives. The PHEP team is responsible for educating the caregivers (family members) on how to look after

their sick and dying. Basic knowledge regarding primary health care and nutrition were noted as the components of this education. Other services offered by the PHEP team when visiting the sick were mentioned by one of the coordinators:

> We visit the sick regularly to monitor their condition, encourage and comfort them and their caregivers. We bath them, and we dress their wounds, do their laundry and clean their home whenever necessary (CD-5 on 20/02/2007).

This response indicates that the PHEP team not only teaches the family members (the caregivers) how to nurse their sick relatives but they also provide physical, psychological and spiritual assistance and care. In addition, the response shows the commitment and love given to the sick, a task that can be carried out by any Christian, and indeed, any individual.

Given that the task of care-giving can be carried out by any Christian, the question that is important for this study is who are the caregivers for people with illnesses related to HIV and AIDS? This question was directed to the implementers of the ELCT Northern Diocese's HIV and AIDS programmes and to congregants. The question sought to discover who the main care-givers for PLWHA within the family and within society at large are, and why. There were basically two responses to this question. The majority of the respondents indicated that family members or relatives are providing care for their sick members. Two reasons were given for this. The first one was that it is their responsibility, and the second reason was that they are closer to the sick persons. However, two of the male respondents remarked that women bear the greatest burden as far as care giving is concerned (ZE-7 on 24/01/2007 & PLWHA-6 on 04/02/2007).

Other respondents also highlighted that it is women who offer care to sick members within the family, while a few noted both women and children as caregivers. It is important to note that the children referred to here are mainly girls since they are expected to continue in their mother's gendered roles of care-giving. Although only a few respondents mentioned women and children, the reasons given by them were typically

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rooted in the gender roles and responsibilities that society has assigned to women. The reasons given as to why women have to provide care to the sick were indicated to be that:

- They are traditionally care providers for the family members.
- They have compassion.
- They are closer to the family members than others.
- They have maternal love/a caring heart/loving care.
- They do not shy away from nursing the sick person.

Although the majority of the respondents stated that people who are sick due to HIV and AIDS related illnesses are cared for by their family members without specifying the gender, it was clearly revealed that women were the pillars in terms of care-giving as was observed by the two male respondents. The failure to highlight the central role of women in this regard may have been related to the fact that men are regarded as breadwinners and that as such, their contribution in food provision for the family counts as part of their involvement in care. However, the physical care such as feeding, bathing, dressing and giving medication are absolutely assumed by women. This is supported in the work of Moji A. Ruele who says: "Care-givers, who in most cases are women, carry the main psychological and physical burden because in most African societies men share very little of the domestic responsibilities and family care with their partners."[512] This suggests that men might be involved in some way with regard to the family maintenance but do not really get involved in the practical care as such.

Furthermore, the reasons given by those who mentioned that women and girls are traditionally caregivers reveal how both men and women have internalised distinct roles for each gender, a pattern of thinking which ultimately has its source in the way people have been brought up (socialization). In this regard, girls are socialized to accept and

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[512] Moji A. Ruele, "Facing the Challenges of HIV/AIDS in Southern Africa: Towards a theology of Life," in Musa Dube (ed), *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in* Theological Programmes, Geneva: WCC Publications, 2003, p. 79. See also A WCC Study Document, *Facing AIDS*. p. 16. Tinyiko Maluleke, "Towards an HIV/AIDS-Sensitive Curriculum," in Musa Dube (ed), *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*, Geneva: WCC Publications, 2003, p. 67. Mascarenhas, *Gender Profile in Tanzania*, p. 49.

internalise domestic roles which place them at the margin of society.[513] In view of the fact that society has assigned women the task of care-giving, it might be regarded as a breach of the norms if men were to assume this task.

In addition, the notion that only women have compassion, maternal love, a caring heart and loving care contradicts God's call for all Christians to show deeds of mercy to the needy. Both men and women are called to love their neighbours and to reach out to those in need of physical, emotional and spiritual assistance. People living with HIV and AIDS in particular, are found within families, and if men fail to love and assist them on the grounds that only women have caring hearts and are compassionate, this is to deny both their Christian faith and Christ's love to all.

With regard to the claim that women are closer to the family members than others, and that women do not shy away from nursing the sick person, this again justifies and is justified by the gendered role that society has ascribed to women in the domestic sphere. Given that the majority of women are not in wage employment, care-giving and other household chores are inevitably left to them. Although not all men work outside the home, due to the fact that care-giving and nursing the sick are associated with women, this means that men would hardly share the responsibility of caring.

It has been noted in Tanzania in general, as well, as elsewhere that women are the main care-givers for sick persons within the family and society.[514] Research conducted in Kagera region in the north-western part of Tanzania found that girl children are taken out of school to care for their terminally ill parents or family members who are based at home after having been discharged from the hospitals.[515] The same study states that women in this region are forced to abandon other productive activities in order to care for and nurse their sick family members. It has also been observed that the presence of the pandemic

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[513] Peasgood et al. (eds), *Gender and Primary Schooling in Tanzania*, p. xi.

[514] Mukangara and Koda, *Beyond Inequalities*, p. 54. See also Mascarenhas, *Gender Profile of Tanzania*, p. 49. Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," p. 15. LWF, *Grace, Care and Justice*: *A handbook for HIV and AIDS work,* Geneva: LWF Publications, 2007, p. 30. Weinreich and Benn, *AIDS-Meeting the Challenge,* p. 75. Mwaura, "Violation of Human Rights of Kenyan Women with HIV/AIDS," p. 128. Ezra Chitando, "Women," p. 188.

[515] Mukangara and Koda, *Beyond Inequalities*, p. 54.

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has increased the workload of women who usually have limited resources to meet the basic needs of the sick and other family members. This economic vulnerability is coupled with the lack of proper knowledge about how to protect themselves from HIV infection, resulting in an even more problematic situation for women.[516]

Given that it is women who provide the care-giving support in Tanzania, the HIV and AIDS programme on care-giving of the diocese targets mostly women and youth (obviously girls).[517] This is unfortunate, because as Siwila notes, the care-giving work of women has not been fair to them due to its impact on their lives.[518] The challenges and issues that women and girls face as caregivers in this era of HIV and AIDS include the risk of contracting the virus in the process of providing care, as well as frequent absenteeism from work and school in the course of nursing the sick, which can cause them to lose their wage employment or to fail in school.[519] I argue therefore along with Siwila that the diocese's programme on care-giving needs to challenge and seek ways to transform gender roles ascribed to women and men, in particular in terms of the ministry of care-giving.[520]

It is also notable that in Chagga society, certain norms are observed with regard to care-giving to persons of the opposite gender. For instance, a woman or a girl cannot bath or dress her sickly father or brother or unmarried young men. These care services can only be offered by a male family member or relative or a neighbour. In line with a feminist cultural hermeneutics,[521] the question is how can this cultural practice be reclaimed as part of the programme on care-giving of the diocese, so that men too can participate in this care-giving?

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[516] Mukangara and Koda, *Beyond Inequalities,* p. 54, See also Phiri, "*African Women of Faith Speak Out in an Era of HIV/AIDS,*" p. 54. LWF, *Grace, Care and Justice*, p. 30.
[517] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 18.
[518] Lilian Siwila, "Care-giving in Times of HIV and AIDS, when Hospitality is a Threat to African Women's Lives: A Gendered Theological Examination of the Theology of Hospitality," in *Journal of Constructive Theology*, 13, 1, (2007), p. 72.
[519] Siwila, "Care-giving in Times of HIV and AIDS," p. 72, 73.
[520] Siwila, "Care-giving in Times of HIV and AIDS, p. 72.
[521] Kanyoro, *Introducing Feminist Cultural Hermeneutics*, p. 64.

Although caregivers are committed and obliged to carry out care-giving, they lack care themselves, something which would enable them to pursue this task more effectively. In other words, the care programme does not cater for caregivers who are physically and emotionally stressed due to the enormity of their task. The importance of providing care for care-givers has been noted by various scholars.[522] Fresen contends that: "These caregivers are the salt of earth. But we need to have policies and practices which prevent the salt from losing its savour."[523] This suggests that the diocese's HIV and AIDS programmes and policy ought to set concrete plans that will nourish and strengthen care providers who are daily overwhelmed with their task of nursing the sick and dying, as well as journeying with and consoling those who are grieving. For instance, organizing weekend retreats for care-givers can empower and strengthen them emotionally and spiritually to cope with their task.[524] It is therefore crucial that HIV and AIDS programmes extend care to the caregivers to minimize stress and burnout.

Besides the cultural resources which can be drawn upon there are also spiritual resources which the programmes of the diocese are using to respond to the needs of PLWHA and their families. The diocese has thus channelled its existing church programmes such as home visits, prayers and the administration of Holy Communion into its response to HIV and AIDS. It is notable that whereas with the physical care-giving it is mostly women who are involved, as regards the spiritual care, this is undertaken mostly by men because they are in the majority among the clergy.[525]

The establishment of support groups for PLWHA represents another programme employed by some of the parishes to address the effects of the pandemic as will be discussed below.

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[522] Fresen, "Responsibility and Caring for one Another," p. 67. See also Daniela Gennrich, *The Church in an HIV+ World: A Practical Handbook,* Pietremaritzburg: Cluster Publications, 2nd edition 2007, p. 70. LWF, *Grace, Care and Justice,* p. 59, 60. Jean Garland, *AIDS is Real and it's in our Church,* Bukuru: Africa Christian Textbooks, 2001, p. 251.
[523] Fresen, "Responsibility and Caring for one Another," p. 67.
[524] Fresen, "Responsibility and Caring for One Another," p. 68.
[525] Here again one notes the dualistic separation of women's and men's roles as noted by feminist theologians – men are associated with the spiritual and women with the material.

5.3.4 Support groups

Whilst above we have concentrated on those who are HIV negative taking care of those who are positive, the diocese also has a programme in some of its parishes[526] for support groups among PLWHA. Here is where those who are HIV positive take care of each other. One of the respondents said:

> One of our tasks as AIDS educators is to encourage people living with HIV to form groups within their parishes so that they can encourage and support each other. PLWHA are still stigmatized, despite the enormous education campaign we offer to the public (CD-5 on 20/02/2007).

The initiative of HIV and AIDS educators to motivate PLWHA to be in solidarity with one another as a way to counteract loneliness and depression is very effective as indicated by some of the respondents:

> The good thing is that we have an opportunity to meet together as a group. We advise and encourage one another. And all of us who have joined Nsia group have undergone HIV testing, so we know our HIV positive status (PLWHA-2 on 19/01/2008).

> The group of PLWHA which is led by the parish pastor meets at Kalimani congregation every Saturday. We convene our meetings, we are involved in sports, and we knit local carpets (*mikeka*). So the parish has given us a space to meet and engage in various activities. We were given money to embark on small enterprises to enhance our income." (PLWHA-5 on 06/02/2007).

> Our group, which is called "*Kikundi cha wanaoishi kwa matumaini Pasua*" (Pasua Supportive Group (PASUG) has decided to assist one another, meeting together, getting involved in sports and traditional dances (*ngoma*) every Saturday. The group members also visit ill people with chronic diseases such as diabetes, stroke and AIDS. Most of PLWHA have no wage employment, so the parish gives them small loans of Tshs. 15 000 (equivalent to U$D 10). We return the loan without interest (PLWHA-6 on 14/02/2007).

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[526] Uduru and Moshi Pasua Parishes have established support groups namely, Nsia and PASUG.

The latter two respondents belong to the same parish. The responses reveal that some parishes have created a space for PLWHA where they can socialize, encourage and support one another. This is to be commended. However, as mentioned above with regard to peer groups' education, support groups need to be spaces where people feel safe to share their innermost feelings and experiences. One cannot assume therefore that the mixed age and gender of the support groups for PLWHA programmes facilitate to the full, the free and open sharing of such feeling and experiences by all group members.

In addition to the formation of support groups for PLWHA another programme of the diocese involves small income generating projects as a way to provide people with adequate nutrition and as a means of poverty alleviation. This will be analyzed below.

5.3.5 Income generating activities

Income generating activities are among the package of HIV and AIDS programmes carried out by the PHEP team. The general comment from the HIV and AIDS programme implementers was that households with people infected and affected by HIV and AIDS are encouraged to embark on small income generating projects such as gardening and poultry production to ensure that they have adequate nutrition to strengthen their immune system as well as to boost the family income. Their argument has gained support from the work of the Lutheran World Federation (LWF) which states: "Nutrition and HIV are strongly interrelated. Good nutrition increases resistance to infection and disease, improves energy and thus can make a person stronger."[527]

The emphasis on income generating activities concurs with Daniela Gennrich who contends that churches ought to assist "communities establish means to bring in income and to strengthen food security."[528] It is evident that the church is in a position to help its members to initiate various generating income projects which will enable them to be self-supportive in terms of food and other basic needs.

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[527] LWF, *Grace, Care and Justice,* p. 76. See also Annamaria Kiure, Gernard Msamanga and Wafaie Fawzi, "Nutrition and HIV Infection" in Max Essex at el. (eds), *AIDS in Africa*, 2nd edition, New York: Kluwer Academic, 2002, p. 422.
[528] Gennrich (ed), *The Church in an HIV+ World*, p. 37.

While the income generation project is commendable, the way in which it was implemented reveals that the diocese has not recognized that such initiatives are required to serve as preventive measures to alleviate the economical situations which force women into risky behaviour. On the contrary, the diocese was only able to identify that income generating projects were important for people who were already living with HIV and AIDS. This was true for both the educators and the congregants. Thus, Rao Gupta argues that the strategy of any gender-sensitive programme dealing with HIV and AIDS is geared toward helping vulnerable women to engage in income generating activities as a *preventative* measure that will lead them to self reliance and to avoid dependence on men, therefore reducing their chances of contracting HIV.

Given that the programmes of the diocese are providing education on income generation without linking it with gender factors that fuel the pandemic, this suggests that the gendered reasoning behind these projects in terms of reducing women's economic dependence on men has been obscured. The diocese is using the programme as only a *coping* strategy for those who are already living with the virus, as opposed to a *preventative* strategy which is what a holistic gender-sensitive programme would be geared toward.

The provision of social support to orphans is another aspect of the programmes initiated by institution/parishes to alleviate the impact of the pandemic as will be explained in the next section.

5.3.6 Provision of social support to orphans

Another HIV and AIDS programme of the diocese is the provision of social support to orphans. The diocese Master Plan concerning HIV and AIDS states that by 2006, there were 73 045 orphans between 0-18 years in the Kilimanjaro region of which 19 034 were from the ELCT Northern Diocese.[529] The estimates nationally as well as within the diocese reveal the increase in the number of orphans as well as child deaths. The

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[529] Burkhardt, "Mpango mkuu wa KKKT DK kupambana na UKIMWI na kusaidia Yatima," p. 2. See also KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 3. Since the latest figure for orphans in diocese is not available, this figure may be higher or less than the 2006 data.

provision of basic needs to orphans was mentioned as an important strategy by the respondents from parishes which are involved in supporting orphans either through parish initiatives or through assistance from various agencies, donors or institutions. One example of such a service of HUYAMWI ministry is run by the Lutheran Bible School Mwika.

HUYAMWI is a Swahili acronym for *Huduma ya Yatima Chuo cha Biblia Mwika* (Orphan Ministry at Lutheran Bible School Mwika). The idea to engage in orphan ministry was initiated by Rev. Dr. Martin Burkhardt, who was a lecturer at the Lutheran Bible School in Mwika (LBS Mwika).[530] He took this step in response to the growing number of orphans within the communities. The special focus of this ministry was on the primary school leavers. Bible study, how to be self- reliant and experiences of orphans were the main themes of the initial work with the orphans. However, sports, singing and various other activities were later also encouraged to facilitate further open discussions with the orphans to ascertain their situation and needs. HUYAMWI offered its ministry to parishes and those that accepted the ministry were required to establish an orphan committee responsible for planning, budgeting and analysing the needs of orphans generally. The parish committee also had the task to identify specific orphans and their individual needs. Lole, Msae, Rau and Kisamo were the first HUYAMWI pilot parishes to be engaged in orphan ministry.

The HUYAMWI ministry includes the provision of school related expenses for orphans at public and private secondary schools and vocational training schools, funds to run income generating projects, medical aid support,[531] and financial support for house construction or renovation for those who required this.[532] The HUYAMWI report of 2006 states that four orphans would complete their secondary education in private schools at the end of 2007, while two were in form one and two in government schools, and that ten males had completed a course in mechanics at Mwika Vocational Training Centre, and

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[530] Personal discussion with Rev. Burkhardt 04/02/2007. See also Martin Burkhardt, "Kamati ya Yatima 06/11/2002," p. 1.
[531] Chuo cha Biblia Mwika, "Taarifa za HUYAMWI: Toleo la kwanza, Machi 2006," p. 3, 4, 5.
[532] HUYAMWI cover 50% of the total cost of the house construction or renovation and the parish offers to pay other half, as they work in collaboration.

passed the VETA[533] blacksmith III examination set by the government, and were thus seeking employment.[534] The report does not identify the gender of those at secondary school. It also indicates that three girls were pursuing computer courses at the Intel training centre in Moshi town and one was studying home craft through VETA.

Besides secondary and vocational training education, the HUYAMWI ministry also trains volunteers, whose tasks include conducting home visits on a regular basis to counsel orphans and identify their needs, and gathering children once a month for socializing.[535] Moreover, seminars on how to run small-income generating projects and loans to initiate these projects are offered to orphan's caregivers (family members) to enable them to have a reliable source of income.[536] The involvement of the LBS Mwika staff in orphan ministry is commendable.

Scholarships for private secondary and vocational education are offered to those who have passed the school entry examination. However, only a few orphans will be beneficiaries of this as indicated above, a situation that demands parishes to initiate other activities to assist the majority who do not qualify for higher education, but who could then join vocational training schools or gain other skills to enable them to be self-reliant. Although the main idea to support orphans with school related expenses is appropriate, some of the training offered to girls perpetuates gendered roles. Home craft training for girls will continue to place them at disadvantaged position in society in terms of their employment. I therefore argue that concerted efforts ought to be made to boost the education standard of girl orphans, which will later provide them with opportunities to get better jobs as a way to minimize their vulnerability to abuse of all forms. Besides the HUYAMWI pilot parishes, individual parishes such as Moshi Pasua[537] and Fuka[538] are

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[533] VETA is the Vocational Education and Training Authority.
[534] Burkhardt, "Handbook of the Orphan Ministry at LBS Mwika (HUYAMWI) paper 9: Review of our Scholarship program 01/06/2006," p. 1, 2. See also Burkhardt, "Mpango Mkuu wa KKKT DK Kupambana na UKIMWI na kusaidia Yatima," p. 6.
[535] Burkhardt, "Handbook of the Orphan Ministry at the LBS Mwika (HUYAMWI) paper 1: Overview of different measures 23/01/2004," p. 1. See also Chuo cha Biblia Mwika, "Taarifa za HUYAMWI," p. 4, 5.
[536] Burkhardt, "Taarifa za HUYAMWI," p. 4.
[537] Solomon Masawe, "Taarifa ya Usharika wa Moshi Pasua 2006."
[538] Cryson Munisi, "Taarifa fupi kuhusu kituo cha Yatima na Maendeleo ya Jamii – Usharika wa Fuka 2006."

also playing a significant role in supporting orphans in terms of their basic needs, with school related expenses regarded as a priority.

Furthermore, an arrangement of HUYAMWI pilot parishes as well as Moshi Pasua and Fuka to set an occasional day aside on which orphaned children are offered a meal, was noted as part of the HIV and AIDS programme activities carried out by the church. Explaining how this activity functions and is sponsored, one of the zonal educators who is also a church elder said:

> We gather orphans occasionally for a meal which is sponsored by parish members. Plans are made to bring the children together to spend the whole day at the parish premises, where activities such as sports, singing and viewing television take place. We usually invite a guest of honour (a political leader) to share the meal with children (ZE-2 on 16/02/2007).

In most cases, it is women who contribute in terms of cash and their time to enable such activities to take place. For instance, it is women who volunteer to prepare the meal for these children, a service they offer whenever there is any parish function. Men can also do the cooking since some are trained as caterers, but since these activities take place on a voluntary basis, they barely take part. This shows the gender stereotypes in the division of labour, in that domestic work is regarded as being mainly for women leading their labour to be discounted as being a valuable resource for which they should be remunerated. However, if the same service is offered by men, they expect to be paid. A critical question we can pose here is: How can we understand the sharing of food together and spending time as a community theologically? As part of its HIV and AIDS programme, the diocese has established an institution (an orphanage) as a response to the challenges posed by the pandemic within the communities. Here too, it is the women who are primarily responsible in nurturing the infants at the orphanage. Given the care-giving roles that women are already engaged in, as we have seen above, for example in palliative care, this task of caring for orphans just adds yet another burden to their already heavy load.

The diocese's HIV and AIDS draft policy has recognized the importance of addressing the social needs of PLWHA which is the topic of the next discussion.

5.3.7 Social support system to PLWHA

Given that people living with HIV and AIDS are severely affected by the pandemic, the diocese's HIV and AIDS draft policy extends various forms of social support to them (PLWHA).[539] The policy states that parishes then have the task to identify these individuals and their needs, and present them to the parishioners and relevant authorities. The Ministry of Health for example provides home based care kits, as well as ARVs and other related medication to the diocese hospitals for those who need them. Meanwhile, the Ministry of Education is responsible for sponsoring orphans who are selected to enrol in public secondary schools.[540] Similarly, the Tanzania Commission for AIDS (TACAIDS) is the government organ tasked with responsible for distributing government funds and other humanitarian social support to non-governmental organisations (NGOs), and faith based organizations (FBOs) that are involved in projects supporting persons living with and affected by HIV and AIDS. The policy therefore states that the diocese will collaborate with all the government agencies and ensure that the government support provided will benefit the intended persons.

To facilitate HIV and AIDS activities and to ensure that the basic needs of the targeted groups are met, the policy document suggests the formation of diaconal committees in local parishes. This in line with Klaus Nurnberger who contends that:

> At parish level a Parish AIDS Committee should be formed, or encouraged and strengthened where it already exists. As far as possible, it should consist of a pastor, a health worker, a social worker (where available), a members of the youth and a person living with the virus.[541]

While forming such a committee will be a positive step, labelling it with the term AIDS will continue to reinforce stigma against HIV positive people because parish members

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[539] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI" p. 13.
[540] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 6.
[541] Nurnberger, *Martin Luther's message for us today,* p. 300.

will refer to "them" instead of "us." In other words, the use of the word AIDS may not always motivate the congregants or the community to participate fully in caring for and supporting the needy with love and generosity, due to the prejudice and judgmental attitudes attached to the pandemic. In addition, it creates the assumption that only those directly infected or affected by HIV and AIDS can be involved. In my opinion, forming a diaconal committee, as suggested by the diocese, is thus more appropriate than an AIDS committee.

The tasks of the diaconal committee, as outlined by the policy document, are as follows:

- To visit the sick and the needy in order to know their needs, to counsel them and to pray with them;
- To register all the needy and assess their problems;
- To prepare the annual activities geared to support persons living with and affected by HIV and AIDS, and to present suggestions to the parish council on how to raise funds to meet those needs;
- To present its activities and data to the leadership of the parish.[542]

The fact that a committee usually comprises few members means that it can probably deal with items 2, 3 and 4, but not with item 1. The first task involves home visits and the provision of counselling and prayer, and thus needs to be undertaken by the entire community so as to avoid burnout by individual volunteers, many of whom have other jobs and family responsibilities. For instance, it would be appropriate for the members of each house-to-house prayer meeting (*sala za nyumba kwa nyumba*) to visit individuals within their locality to pray with them and to provide counselling wherever necessary. Members in each such small cell know who the needy people within their area are; hence they are in a better position to organize a roster to minister to them in turns, so that every individual takes part.

In view of this, it is clear that, by entrusting to the committee the task of spiritual or pastoral care, the diocese has realized the magnitude of the pandemic and that this task

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[542] KKKT, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 16.

cannot be carried out by the ordained only, but needs to be shared by other congregants. This however needs to extend even beyond the committee members for the reasons outlined above. In this case, the church is acting in accordance with the theology of the priesthood of all believers, in which each individual has a role to play in building up the body of Christ. However, while some individuals might have a gift for counselling, it is crucial for the diocese to equip them with appropriate formal skills in this regard since this will increase their effectiveness and also make them aware of issues of confidentiality. The destruction brought by the pandemic has also challenged the diocese to employ a multi-sectoral approach to reach out the afflicted and to conscientize all its adherents to be involved in the activities that address the effects of HIV and AIDS, as mentioned earlier. This forms my next topic.

5.4 A multi-sectoral approach in response to HIV and AIDS pandemic

In working to correct the fact that matters surrounding HIV and AIDS were shouldered since 1983 by a single unit of the diocese - the public health education programme (PHEP) unit, the policy document has introduced a multi-sectoral approach in response to the pandemic which will involve all organs of the diocese ranging from parishes to diocese departments and institutions.[543] Since the involvement of parishes in this matter has already been discussed above, we will now look at the role of the departments and institutions of the diocese. According to the policy, these organs are required to do the following. [544] First, each organ is to develop its own departmental or institutional plan which will indicate its contribution in relation to the objectives of the HIV and AIDS policy.[545] The second task of each organ is to prepare its annual activities and budget in relation to the objectives; and to secure funds to address them whenever possible. Each department and institution can therefore contribute to the objectives of the policy as illustrated on the table below.

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[543] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 17.
[544] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 17.
[545] The objectives of the HIV and AIDS draft policy are: a) to eliminate HIV infection; b) to encourage and enable Christians and non-Christians to undergo HIV testing; c) to provide humanitarian social support to PLWHA; d) to provide treatment to PLWHA; e) to ensure the continuum care of PLWHA; f) to provide guidelines for all projects geared to support PLWHA within the diocese.

Table 7: The involvement of the departments and institutions in addressing HIV and AIDS pandemic

Department/ Institution	Prevention	Medical care	Social support	Capacity building
Medical	Teach about medical issues	Provide medical care for PLWHA	Establish social medical fund	Train medical staff, provision of medical equipment, TOT
PHEP unit	Teach about health care and HIV and AIDS	Home-based care (HBC)	Counselling and psychological support	Train HBC providers
Diaconal	Teach about diaconal ministry and caring for PLWHA	Social funds for diaconal work	Various forms of social support to the needy	Train congregants on diaconal issues
Education	Teach on prevention, behaviour change and Christian ethics	Teach Christians about HBC	Teach about the role of a Christian with regard to his/her neighbour	Training of trainers (TOT)
Women	Teach women how to prevent HIV infection and care for PLWHA	Train women on HBC	Train women on their responsibility to society (*Diakonia)*	Training of women leaders
Youth	Teach young people how to protect	Train young people on HBC	Train young people on their	Training of youth leaders

	themselves from HIV infection and to care for PLWHA		responsibility to society (*Diakonia*)	
Project	Teach diocese workers how to protect themselves from HIV infection	Encourage diocese employee to undertake HIV testing	Provide small income generating projects	Training on project management
Tertiary/schools and others	Teach workers and students how to protect themselves from HIV infection	Teach workers about HBC	Teach workers about their responsibility to society	Training of trainers (TOT)
Kindergarten /primary schools	Teach children how to protect themselves from HIV infection	Train children on HBC	Teach children about their responsibility to society (*Diakonia*)	Train teachers and children leaders
Hospitals and dispensaries	VCT and seminars about prevention	The package of HIV and AIDS treatment including HBC	Social medical care	Train medical staff, HBC providers and conduct research

Source: Sera ya Dayosisi ya Kaskazini ya Kupambana na Virusi vya UKIMWI na UKIMWI

The above table shows that each department and institution has a role to play in prevention, medical care, social support and capacity building. As regards prevention, the Christian Education Department is responsible for bringing about behaviour change

which has to do with sexual ethics, but the policy does not clarify the available resources that will be employed to facilitate this change of behaviour and adherence to Christian ethics. Since the majority of Chagga men indulge in multiple sexual partnerships, it is the task of this department to set up programmes to reach men of all age groups to discuss their risk taking behaviour and their responsibility to contain the pandemic. In other words, no behaviour change will take place in the absence of gender sensitive programmes which address the needs of each gender, and the root causes that prevent behaviour change from being possible.

Similarly, the Women Department is required to teach women on how to prevent HIV infection and to care for PLWHA. This implies that women can only be infected through providing care for people living with HIV and AIDS. While knowledge on how to protect themselves during the process of nursing is vital, it is marital relationships which are the main route through which women contract HIV infection, a fact that goes unmentioned. This reveals the diocese's gender insensitivity since the need to empower women and girls is apparently beyond its concern or awareness.

Meanwhile, the Youth Department is given the task to educate young people on how to protect themselves from infection as well as to care for sick individuals. As discussed above, the policy insists on abstinence for young people as the only possible preventive strategy as regard HIV infection. Self-discipline in sexual matters can certainly protect individuals from HIV infection, but not all can comply with this because of the prevailing social and economical factors as well as due to peer pressure. For instance, the high rate of teenage pregnancies, as discussed in detail in chapter four, is an indication that boys and girls are sexually active at an early age. In view of this, proper sex education to guide young people to responsible sexual behaviour is a must. Furthermore, since a number of out-of-school young people are unemployed, the church needs to fund them to run small income generating projects to enable them to be self-sufficient, hence removing the need (especially among girls) to exchange sex for money. Generally, each department and institution has the task to impart prevention knowledge to its target groups, but resources to address this problem are not articulated adequately.

With regard to medical care, home based care falls under this section. The table shows that home based care training is to be expanded to various groups in society but women and youth (obviously girls) are the main focus in this. The justification for this as outlined above, is based on the traditional gender roles and expectations of society which ascribe to women the role of caregiver for sick people in the family and society. In the era of HIV and AIDS, giving care to the sick calls for a joint effort from all categories of people in the family and society to share this responsibility as part of showing their Christian faith to people in need.

In terms of social support, the importance of teaching Christians about their responsibility to show Christ's love to the needy (*diakonia*) as is a fundamental part of the Christian faith is emphasized with regard to each category of people. Thus, the Project Department has the task of sponsoring individuals afflicted with the pandemic to allow them to embark on small income generating projects that will enable them to meet their basic needs. As discussed earlier, the income generating projects of the diocese are not linked with gender factors that reinforce the spread of HIV but rather serve as a coping mechanism for the individuals already living with and affected by HIV and AIDS.

Finally, the training of trainers, which is a strategy to equip more congregants with skills and knowledge to assume various tasks surrounding the pandemic, is according to the HIV and AIDS policy to be undertaken by all diocese organs. However, this task falls under the Women and Youth Departments and only women and youth leaders are thus singled out for training. After training the leaders, these individuals will in turn also impart their knowledge to members of their groups, enabling everyone to participate in ministering to those in need. What is problematic is that once again, men seem to have been excluded from this training process which focuses mainly on women and youth.

The fact that both the church and government are involved in responding to the HIV and AIDS pandemic requires a comparison of their respective programmes and policies in order to ascertain in particular how each responds to gender-related issues, which is my next discussion.

5.5 Government and diocese: a comparison of HIV and AIDS policies/programmes

As the diocese draft policy has not been implemented, it is hard to comment on its effectiveness. As stated earlier, the policy content reflects to a great extent the current diocese HIV and AIDS programmes. While some of the church programmes are similar to those of the government, the government is more aware of gender issues than the diocese. Both the church's and government's programmes/policies have prioritized HIV and AIDS education awareness as the main strategy in the prevention of the transmission of HIV. Similarly, for both, medical care, voluntary counselling and testing, the treatment of the opportunistic infections, the provision of antiretroviral drugs and home-based care are governed by the Ministry of Health. In addition, the provision of care and social support for people living with and affected by HIV and AIDS are stated as goals in both policies.

Despite these similarities however, there are differences between the diocese and the government HIV and AIDS policies. The government HIV and AIDS policy reveals a greater concern with regard to human rights and gender issues than that of the church. Given that the main mode of HIV transmission is through heterosexual intercourse, the government policy states that women need to be empowered to negotiate for safer sex.[546] It further states that men and women ought to be accorded equal status as well as equal opportunities for education, access to reproductive health education and access to health care services and leadership in all spheres of society. To translate these ideas into practice, the policy suggests five strategies.[547] First, the unequal power relations which prevent women from protecting themselves from HIV infections will be addressed. Second, cultural institutions and traditional practices that provide opportunities for education leading to increased public awareness will be utilized for empowerment and dissemination of information, education and communication (IEC) on reproductive health as well as HIV and AIDS. Third, community programmes will address the danger of multiple sexual partners, and the issue of reproductive rights in relation to the transmission of HIV. Fourth, all treatment related to reproductive health will be made

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[546] United Republic of Tanzania, *National Policy on HIV/AIDS,* p. 21.
[547] United Republic of Tanzania, *National Policy on HIV/AIDS*, p. 21, 22.

accessible for women, men and youth. Fifth, inheritance laws that prohibit women from owning property will be reviewed. In fact, if these suggestions have been implemented from the time the policy was launched in 2001, HIV and AIDS would not have reached such an alarming rate in Tanzania as it has today.

As discussed in chapter four, eighty five percent of societies in Tanzania are patriarchal in that males dominate all aspects of life in the social, cultural, religious and political sphere. This implies that women are at the receiving end and harder hit by the pandemic than men. Women are the main caregivers to PLWHA, and are besides, themselves infected with HIV. Although the government has tried to apply affirmative actions aiming to give more women access to formal education, wage employment and leadership positions in the civil and political arena, these have been little more than a token gestures until now, as discussed earlier. Likewise, property ownership for women is not secure, forcing them into positions of subordination: also inheritance law, including land tenure, is governed by patriarchal customary traditions which position women secondary to men in all spheres. This issue was elaborated on in chapter four. I therefore argue that the effectiveness of the constructive ideas on gender that have been outlined above will depend entirely on improving the mutual relationship between males and females.

5.6 Conclusion

The objective of this chapter was to offer a gendered analysis of the HIV and AIDS programmes and policy of the diocese. The diocese's HIV and AIDS programmes cover three areas. Programmes on HIV and AIDS education awareness, programmes that deal with medical care and programmes that deal with social and spiritual care. These were discussed in detail in the chapter. What I found in the diocese programmes/policy was that most of them lack an awareness of the gender dynamics which play a role in HIV prevention and in care-giving in the context of HIV. Comparing the government and church HIV and AIDS programmes/policies brought me to the conclusion that these are related. They include similar provisions for education campaigns, medical care, and a social support system for individuals living with and affected by HIV and AIDS.

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However, the government policy has taken into account gender issues related to HIV and AIDS, even if the implementation of such considerations is pending. The critical re-examination of these policies and programmes remains vital in order to address the gender issues that affect the exposure of both men and women to HIV infection. While this chapter offered a gendered analysis from a sociological perspective (relying on Rao Gupta's conceptual framework), and a cultural perspective (relying on Kanyoro's feminist cultural hermeneutics), in the next chapter I will examine the theological underpinnings of the programmes and assess to what extent these theological motivations are gendered.

CHAPTER SIX

THEOLOGICAL BELIEFS UNDERGIRDING THE HIV AND AIDS PROGRAMMES OF THE ELCT NORTHERN DIOCESE

6.1 Introduction

In the previous chapter, the current HIV and AIDS programmes/policy of the diocese were presented. These range from HIV and AIDS education awareness, voluntary counselling and testing, the provision of antiretroviral drugs, and prevention of mother-to-child transmission to general physical and spiritual care for the sick, the establishing of support groups for people living with HIV and AIDS, income generating projects and provision of social support to orphans. In this chapter, I will describe the theologies underpinning the above-mentioned programmes, and assess to what extent these encourage gender-awareness and sensitivity. Whilst the ELCT Northern Diocese has not been overt in declaring which theological viewpoints under-gird its HIV and AIDS programmes and policy, my research has unearthed some implicit theologies which drive the programmes. These include a theology of good works, the concept of love to one's neighbour, a theology of the freedom of a Christian and of the priesthood of all believers. These theological viewpoints are based on Lutheran doctrine and on some of Luther's lived theologies. The chapter will further look at the mission of the Lutheran Church in the context of HIV and AIDS. In this regard, Luther's response to the bubonic plagues will be considered in relation to the response of the diocese to HIV and AIDS, followed by a critical reflection on his theologies. The central focus of the chapter is therefore: to describe the theological beliefs that underpin the diocese's HIV and AIDS programmes, starting with an identification of some of the Lutheran doctrines which form Lutheran theology (Lutheranism)[548] and of Luther's theologies that are the basis of the diocese's HIV and AIDS programmes.

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[548] Lutheranism is based on the Lutheran Confession. Nurnberger describes Lutheranism as "the prototype of a denomination based on a definite set of confessional writings which have been closed since the 16th century." Nurnberger, *Martin Luther's message for us today*, p. 278. Whilst, Luther's theology is grounded in his teachings which addressed issues of his time in a broader context – social, economical, political and spiritual.

6.2 Lutheranism and Luther's theologies as the basis of the diocese's HIV and AIDS programmes

6.2.1 A theology of good works

Of the twenty-eight Articles of Faith and Doctrine of the Augsburg Confession, Article 6 on the "New Obedience" serves as a theology, underpinning the HIV and AIDS programmes of the diocese. The article states that:

> Our churches also teach that this faith is bound to bring forth good fruits and that it is necessary to do the good works commanded by God. We must do so because it is God's will and not because we rely on such works to merit justification before God, for forgiveness of sins and justification are apprehended by faith, as Christ himself also testifies, When you have done all these things, say, 'We are unprofitable servants' (Lk. 17:10).[549]

The Article is clear regarding the responsibility of the church to teach its adherents about the basis of their Christian faith, and the importance of practicing good works which have been commanded by God. The "faith" which the Article refers to, highlights that people cannot save themselves, but it is God through Christ who accepts them by grace.[550] It further argues that doing good works does not justify a person before God, but forgiveness of sin and righteousness come through faith in Christ. Individuals involved in HIV and AIDS work believe that in whatever way they were helping persons living with and affected by HIV and AIDS they were practicing their Christian faith which demands them to love their neighbours. Their good works include visiting the sick and orphans, counselling them, comforting them, encouraging and reminding them to take their medication, motivating them to embark on small-scale income generating projects and to form support groups for individuals living with HIV and AIDS. The theological concept of "love your neighbour" is the next theology suggested to be underpinning the diocese's HIV and AIDS programmes.

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[549] Theodore Tappert (ed), *The Book of Concord: The Confessions of the Evangelical Lutheran Church,* Philadelphia: Fortress Press, 1959, p. 31, 32.
[550] George W. Forell, *The Augsburg Confession: A contemporary commentary*, Minneapolis: Augsburg Publishing House, 1968, p. 32.

6.2.2 The theological concept of love for one's neighbour

Describing what love is, Anders Nygren maintains: "it belongs to the characteristic and central elements in Christianity."[551] In view of this, he argues that God's work of salvation and that of Christ are grounded in God's love (Jn 3:16). Similarly, human beings must love both God and their neighbour, as summed up in the twofold commandment to love (Mk. 12:30-31). For this reason, love is central to Christianity from a religious and an ethical perspective.[552] Luther concurs with Nygren in this respect. However, Luther puts an emphasis on faith alone as determining the human relationship with God.[553] He argues that we attain salvation, not through our strength, merits or good works but because of faith in Christ. He adds that Christians are commanded to love their neighbour in a way which: "seeks not its own but gives to the neighbour the love of Christ freely and without expectation of reward."[554] Emphasizing this love, Luther argues that a Christian is called to be "a Christ to his [sic] neighbour."[555] This suggests that Christians have to love their neighbour the way Christ loves us all.

Luther's explanation of love is summarized in his Small Catechism which forms a basis for the Lutheran teachings. He admonishes parents to teach their children the basics of the faith, which include the Ten Commandments, the Creed, the Lord's Prayer, the Sacrament of Holy Baptism, Confession and Absolution, the Sacrament of the Altar, Morning and Evening Prayers and Grace at Table.[556] For the purposes of this study, I want to examine the Ten Commandments. Luther maintains that the Ten Commandments are the good works commanded by God.[557] He sums up the message of the Commandments by referring to the words of Paul in Romans: "Love your neighbour as yourself" (Rom.13:9).[558] For Luther love for one another is "a fruit of divinization."[559]

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[551] Anders Nygren, "Love," in Julius Bodensieck (ed), *The Encyclopedia of the Lutheran Church*, Vol. 11, Minneapolis: Augsburg Publishing House, 1989, p. 1345.
[552] Nygren, "Love," p. 1345.
[553] Nygren, "Love," p. 1347.
[554] Nygren, "Love," p. 1347.
[555] Nygren, "Love," p. 1347.
[556] Martin Luther, "The Small Catechism," in Theodore Tappert (ed), *The Book of Concord: The Confessions of the Evangelical Lutheran Church*, p. 342-354.
[557] Martin Luther, "Treatise of Good Works, 1520," in James Atkinson (ed), *Luther's Works,* Vol. 44, Philadelphia: Fortress Press, p. 19.
[558] Luther, "The Small Catechism," p. 356.

This implies that our love for our neighbour is rooted in God's love and goodness and living out this commandment brings us closer to God, the divine.

Volunteers visit the sick, pray with them, comfort them and in some cases are compelled to provide cash or clothes to individuals or families in abject poverty. For instance, one of the respondents explained how circumstances forced her to take some of her clothes to a widow who was after her husband died of HIV and AIDS related illnesses ill-treated by her in-law and who was herself also HIV positive. She maintained that: "I have to support her because that is what it means to be a Christian. Failure to help her is to deny my faith" (ZE -4 on 24/01/2007). Another respondent narrated the way she had to pay several visits to her neighbour (a young male) who was sick for a long time but refused to seek treatment (ZE-1 on 16/02/2007). She managed to convince him to go to the hospital and where he was tested and found to be HIV positive, after which he received life saving medication. In the next section, I will discuss a theology of the freedom of a Christian.

6.2.3 A theology of the freedom of a Christian

In his treatise on the freedom of a Christian, Luther highlights two important aspects with regard to Christian faith. First, "a Christian is a perfectly free lord of all, subject to none. Second, a Christian is a perfectly dutiful servant of all, subject to all."[560] Luther acknowledges that both statements are grounded in Pauline teachings. With regard to his own freedom, Paul claims that, although he is a free person, he has made himself a servant to all (1Cor. 9:19) through his ministry. Further, Paul claims that, what is required from him is to love the other (Rom. 13:8). In view of these arguments, Luther contends that love is always ready to serve and to be subject to the person who is loved. Clarifying on Christian freedom and servanthood, Luther refers to Christ's statement that, although

[559] Sigridur Halldorsdottir, "A Caring Community," in Palvi Jussila (ed), *See How They Love One another: Rebuilding Community at the Base*, Geneva: LWF Publications, 2002, p. 43.
[560] Martin Luther, "The Freedom of a Christian," in Harold J. Grimm (ed), *Luther's Works,* Vol. 31, Philadelphia: Muhlenberg Press, 1957, p. 344. See also Martin Luther, "The Freedom of a Christian," in Timothy F. Lull (ed), *Martin Luther's Basic Theological Writings*, Minneapolis; Fortress Press, 1989, p. 596. Martin Luther, "The Freedom a Christian," in Philip D. W. Krey and Peter D. S. Krey (eds), *Luther's Spirituality*, New York: Paulist Press, 2007, p. 69. Steven Paulson, *Luther for Armchair Theologians*, Louisville: Westminster John Knox Press, 2004, p. 183.

he was God, he was born of a woman and born under the law (Gal. 4:4). Christ was thus a free person and a servant at the same time, "in the form of God and of a servant."[561]

Luther asserts that Christians do not live in this world to work for themselves, but for others. In this case, Christians subject themselves to others as they freely offer their services to those who need them.[562] He further maintains that a person's obligation to another does not accord them salvation or righteousness. A person needs to be made aware that, whatever service they provide, they should not expect to be rewarded. He concludes his explanation of Christian liberty by saying that:

> a Christian lives not in himself, but in Christ and his neighbour. Otherwise he is not a Christian.
> He lives in Christ through faith, in his neighbour through love. By faith he is caught up beyond
> himself into God. By love he descends beneath himself into his neighbour.[563]

Luther's statement emphasizes that Christians are not alone. The faith of Christians in Christ demands them to love and serve those in need. This action expresses the servanthood of Christians and the freedom they have as Christians. For example, one of the PHEP team indicated that they don't only teach the family members how to care for their sick relatives, but they also themselves provide physical care to the sick such as bathing them, dressing their wounds and do their laundry (CD-5 on 20/02/2010). This reflects freedom and true servanthood. Another example concerns the commitment of a respondent[564] who accepted to be a caregiver for the twins of a single HIV positive mother. The mother was hospitalised a few months after delivery and was in a critical condition. An eight-year old girl brought the infants to the respondent during the week of concentrated public health education in her congregation. The infants were also HIV positive. They were five months old at the time, and by 4th February 2007 when I interviewed the respondent, they were two years and five months old (OP-3 on

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[561] Luther, "The Freedom of a Christian," p. 344.
[562] Luther, "The Freedom of a Christian," p. 365.
[563] Luther, "The Freedom of a Christian," p. 371.
[564] This respondent was one of the older congregants. She is a nurse by profession and a counsellor working with the government – basically involved in public health education. Besides, she was the chairperson of the women's group in her parish.

04/02/1007). The priesthood of all believers is the theology that will be dealt with in the next section.

6.2.4 A theology of the priesthood of all believers

To counteract the Roman doctrine which exalts the ordained as the only people who are qualified for the ministry of the church, Martin Luther introduced the doctrine of the priesthood of all believers.[565] Luther's concept is based on the Scripture which says: "But you are a chosen race, a royal priesthood, a holy nation" (1 Peter 2:9). He emphasizes that all Christians are priests, and those who are ordained are ministers chosen from among the community of believers. Therefore, whatever they do, they do on behalf of the community.[566] For Luther, the priesthood is a ministry and not a vocation, which means that it can be practiced by anybody. He contends that: "Every Christian is a priest by virtue of his [sic] baptism. This priesthood derives directly from Christ."[567] In Luther's view every baptized Christian is called through baptism to be a servant of Christ and to be a steward of the mysteries of God (1 Cor. 4:1). He insists that the priesthood of all believers is "a responsibility as well as a privilege, a service as well as a status."[568]

Luther's emphasis on the universal priesthood of believers is reflected in at least three areas of his theological thinking. First, in his Treatise on the Sacrament of Penance, where Luther spells out that the declaration of absolution is open to every believer and is not merely the task of the ordained clergy.[569] He claims that: "God alone forgives sin, and in God's name "every Christian, even a woman or child," may declare the forgiveness of sin to a repentant brother [sic]."[570] Luther wants to show that the inward part of this service is done by God, and therefore the outward part can be done by any Christian,

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[565] William Lazareth, "Priest & Priesthood," in Julius Bodensieck (ed), *The Encyclopedia of the Lutheran Church,* Vol. 3, Minneapolis: Augsburg Publishing, 1965, p. 1966.

[566] Martin Luther, "The Babylonian Captivity of the Church," in Abdel Ross Wentz (ed), *Luther's Works,* Vol. 36, Philadelphia: Fortress Press, 1959, p. 113.

[567] Timothy George, *Theology of the Reformers*, Nashville: Broadman Press 1988, p. 96. See also Bernard Lohse, *Martin Luther's Theology: Its Historical and Systematic Development*, Minneapolis: Fortress Press, 1999, p. 290.

[568] George, *Theology of the Reformers*, p. 96.

[569] Lazareth, "Priest & Priesthood," p. 1966.

[570] Lazareth, "Priest & Priesthood," p. 1966.

even, in this context, by the marginalized, women and children who were at that time considered incapable of playing any significant role in the life of the church.

Another area in which Luther advocates the universal priesthood of believers, concerns the work of Reformation. In his open letter to the Christian nobility in Germany, he insists that it is appropriate for lay Christians to be involved in reforming the church instead of leaving this task to the priests alone. He argues that:

> Since those who exercise secular authority have been baptized with the same baptism, and have the same faith and the same gospel as the rest of us, we must admit that they are priests and bishops and we must regard that their office is one which has a proper and useful place in the Christian community. For whoever comes out of the water of baptism can boast that he is already a consecrated priest, bishop, and pope, although of course it is not seemly that just anybody should exercise such office.[571]

Luther justifies his argument in favour of involving lay people in the reshaping of the church on the grounds that they have undergone baptism, believe in the same Christ, and use the same gospel. For this reason, he regards them as church leaders – bishop, priest and pope and he believes that they have the potential to introduce changes in the church.

Luther therefore views the ordained ministry as a single service among many other Christian services. The priests are involved in spiritual matters while lay people are involved in social matters.[572] This suggests that the Reformation was not concerned with spiritual affairs only but also with social issues. For this reason, each group - the ordained and the lay ministry - was of equal importance in the struggle for Reformation in church and society.

The third area where Luther believed lay persons ought to be active was that of teaching children about the basics of Christian faith (the catechism), a task that was until Luther's

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[571] Martin Luther, "To the Christian Nobility of the German Nation Concerning the Reform of the Christian Estate," in James Atkinson (ed), *Luther's Works,* Vol. 44, Philadelphia: Fortress Press, 1966, p. 129.
[572] Lazareth, "Priest & Priesthood," p. 1966.

time, exclusively carried out by priests.[573] Luther relegated this responsibility to parents who were lay Christians. As Luther was introducing the catechism to his congregants in Wittenberg, he admonished parents, saying that: "Every father of a family is a bishop in his house and the wife a bishopess. Therefore remember that your homes are to help us carry on the ministry as we do in the church."[574] In this case, Luther regards parents as bishops in the household who have to set aside time to instruct their children and all other members of their household on Christian faith, just as bishops/priests do in their dioceses/parishes. It is notable that men and women were both and equally entrusted with this task. The catechism entails the Ten Commandments, the Creed, the Sacraments of Holy Baptism and the Lord's Supper, Confession and Absolution, Morning and Evening Prayers, Grace at Table and Table of Duties.[575] According to Luther, the foundational teachings in the catechism help to shape individuals into good citizens.[576] Indeed, good citizens who fear God, respect others and are responsible in every aspect, form the greatest asset for any community.

Having highlighted these aspects of Luther's theologies, centering on Christian life and everyday affairs, it is evident that all Christians are seen as qualified to assist people living with and affected by the HIV and AIDS pandemic. The fact that the church is the body of Christ means that it must play its role by reaching out to the needy and assisting them with all their requirements in order to promote life and uphold their dignity. All the above discussions are associated with the mission of the church. This is the specific topic of the next section.

6.3 The mission of the Lutheran Church in the context of HIV and AIDS

Mission refers to "God's saving work and the church's participation in that work."[577] The Lutheran World Federation (LWF) states that the mission of the church has its origin in

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[573] Timothy J. Wengert, *Martin Luther's Catechisms: Forming the Faith*, Minneapolis: Fortress Press, 2009, p. 17.
[574] Martin Luther, "Ten Sermons on the Catechism 1528," in John Doberstein (ed), *Luther's Works*, Vol, 51, Philadelphia: Muhlenberg Press, 1959, p. 137. See also Wengert, *Martin Luther's Catechisms*, p. 17.
[575] Luther, "The Small Catechism," p. 342, 343.
[576] Luther, "The Sermons on the Catechism," p. 137.
[577] Ishmael Noko, "Mission and Development," in LWF Documentation, *Stewardship: Our Accountability to God*, No. 34, (April 1994), p. 9.

the mission of God, and that the church is called on to participate in God's mission by words and actions.[578] The LWF further notes that regardless of the sinful nature of human beings, God uses them to: "manifest the divine purposes of creation, justice and salvation, and display His [sic] unmerited grace and love among all people."[579] The church is involved in this *missio Dei* to bring the salvation and justice which reveal God's love and grace to all of creation. This implies that God's mission does not encompass only spiritual affairs but also the social and economic wellbeing of humanity. In other words, the *missio Dei* has to deal with the whole of the person. This resonates with Nurnberger, a Lutheran theologian, who maintains that the mission of the church is not confined to spiritual matters. The mission has to address the contemporary issues that are evident among God's people such as poverty, violence and illiteracy.[580] In this regard, the proclamation of the word and acts of service has to go hand in hand.

Mission work is to take place locally and globally, as Jesus indicated to his disciples in Acts: "But you will receive power when the Holy Spirit has come upon you; and you will be my witnesses in Jerusalem, in all Judea and Samaria, and to the ends of the earth" (1:8). Another Lutheran theologian Ishmael Noko, as well, asserts that the mission of the church is classified into the divisions "foreign" and "home," and that the word mission describes "all the activities that the church is sent to do in the world which are to love, to heal, to preach, to liberate and to reconcile."[581] He emphasizes that *missio Dei* is not aimed only at people who do not belong to a church, but includes those within the church. This is to say that any service or ministry carried out by the church to reach humanity, has a missionary dimension.

For instance, the involvement of the church, through various ministries, in responding to the challenges posed by HIV and AIDS, as discussed in the previous chapter is part of

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[578] LWF, *LWF Documentation- Together in God's Mission: An LWF Contribution to the Understanding of Mission*, No. 26, (November 1988), p. 8. See also DMD Themes, "The Lutheran World Federation: Department for Mission and Development," <http://www.lutheranworld.org/what_we_do/DMD/Themes/DMD-Mission.html> Accessed: 11/9/2009, p. 1.
[579] LWF, *LWF Documentation*, p. 8.
[580] Nurnberger, Martin Luther's message for us today, p. 149.
[581] Noko, "Mission and Development," in LWF Documentation, *Stewardship,* p. 9.

God's mission to God's people. Those who are reached are members of the body of Christ. The massive impact of the pandemic does not only involve local churches, but also the church on a national and international level. Lutheran World Federation (LWF) as a global communion of Lutheran churches has established an HIV and AIDS Action Plan in 2002 to promote, to strengthen and to support the urgent response of member churches to HIV and AIDS.[582] The plan was instituted because church members are infected and affected by the pandemic. In other words, "the church itself has HIV/AIDS."[583] The Action Plan states, "When one part of the body of Christ suffers, all of the body suffers."[584] It reflects the fact that when one person within a community is in crisis, it affects the entire community in many ways. Through time spent and resources exhausted in the caring for and the supporting of the infected and affected are aspects of the pandemic, which impact on individuals as well as communities. Compassion, Conversion and Care are three themes of the Action Plan that guides the churches in their response to HIV and AIDS.

The first theme reminds the church, that people living with HIV and AIDS are created in the image of God and that they are Christ-like persons in our midst; therefore the church has to be compassionate and address their suffering with unconditional love, acceptance and support.[585] The next theme cautions and urges the church to consider PLWHA as useful resources who have something to offer to the community regardless of their condition.[586] The Action Plan document states that people who are willing to speak openly about living with HIV make a tremendous contribution by inspiring the church and individuals to stop stigmatizing and excluding PLWHA, and to meet the challenges posed by the pandemic with courage. Hence, the church is called to repent and to embrace those whom they have neglected and ostracized by welcoming them, providing correct information to them and to the community at large, and by engaging in activities,

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[582] Frank Imhoff, "LWF Global Campaign against HIV/AIDS Launched,"
<http://www.wfn.org/2002/05/msg00042.html> Accessed: 11/10/2008, p. 1.
[583] LWF, "Compassion, Conversion and Care: Responding as churches to the HIV/AIDS pandemic-An Action Plan of the Lutheran World Federation,"
<http://www.lutheranworld.org/LWF_Document/HIV/AIDS_Acton Plan.pdf >Accessed: 11/10/2008, p. 1.
[584] LWF, "Compassion, Conversion, Care," p. 1.
[585] LWF, "Compassion, Conversion, Care," p. 2.
[586] LWF, "Compassion, Conversion, Care," p. 3.

promoting life-giving support for HIV positive people.[587] The final theme reminds the church about its task to offer care for people living with and affected by HIV and AIDS and to speak the truth about the pandemic and its prevention.[588] Each of the three themes demands that the church acts urgently and responsibly. The LWF response to HIV and AIDS was a reminder to its member churches, such as ELCT Northern Diocese, to participate fully in God's saving work (mission) within their locality, in the manner in which Luther responded to the bubonic plague of his time as will be discussed later.

Scherer refers to scholars such as Warneck and Plitt who criticize Martin Luther for his lack of interest in mission work abroad during the time of the Reformation.[589] However, this charge has been attributed to a narrow understanding of mission as an activity, meant to take place in foreign lands or among non-Christians only. Although Plitt concurs with Warneck, he argues that Luther and his companions had the task to preach the gospel anew in Germany to counteract the "false doctrine" of the Roman Church.[590] He further maintains that: "For Luther, mission was the essential task of the church in every age, but only a church itself grounded in the gospel could do mission."[591] Luther's stance concerning the obligation of the church to carry forth the missionary work until the return of Christ is clearly demonstrated, but he cautioned that mission is possible only if the church lays its foundation in the gospel. Luther's initiative to preach the gospel among his own people is parallel to Jesus' commission to his disciples that missionary work was to start in Jerusalem and from there spread to other parts of the world.

The LWF states clearly that all Christians are called through baptism to participate in God's mission.[592] The mission of God is twofold: the proclamation of the gospel and deeds (actions of love and compassion). Of all the Reformers, only Luther introduced the

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[587] LWF, "Compassion, Conversion, Care," p. 3.
[588] LWF, "Compassion, Conversion, Care," p. 3.
[589] James A. Scherer,…*that the Gospel may be sincerely preached throughout the world,* LWF Report 11/12, 1982, p. 5. See also, Andrew Burgess, "Missions (Lutheran World Missions)," in Julius Bodensieck (ed), *The Encyclopedia of the Lutheran Church*, Vol. 11, Philadelphia: Fortress Press, 1965, p. 1619. W.G. Polack, *Into All the World The Story of Lutheran Foreign Missions*, St. Louis: Concordia Publishing House, 1930, p. 35.
[590] Scherer,…*that the gospel may be sincerely preached throughout the world*, p. 6.
[591] Scherer,…*that the gospel may be sincerely preached throughout the world*, p. 6.
[592] LWF, LWF Documentation, No. 26, November 1988, p. 9

doctrine of the priesthood of all believers, as discussed at length earlier. Although Luther insisted on the responsibility of each believer to be a messenger of the gospel, he regarded the ministry of the word and sacraments as the highest office in the church and one for which only males were appropriate candidates. Luther's exclusion of women from the ministry of the Word is contrary to the gospel and denies female members of the body of Christ to exercise their God given talents and fulfil their divine mission.[593] This denial means that in missionary work, men and women cannot offer their service at equal levels because of their distinct genders. It also implies that in respect to charitable services and *diakonia*, the contribution of males is more valuable than that of women. I will develop this idea later in critical reflection on Luther's theology.

Although Ingemar Oberg indicates that Luther did not comment extensively on missionary work,[594] he wrote a number of encouraging pastoral letters to his adherents in response to their plight or difficult situations they encountered such as sickness, famine, epidemics, persecution and death, which themselves can be considered as part of Luther's missionary work.[595] Below I shall examine Luther's response to the bubonic plague and how it can be used to assess the current HIV and AIDS programmes of the Northern Diocese.

6.4 Luther's response to the bubonic plague in relation to the HIV and AIDS programmes of the ELCT Northern Diocese

One of Luther's pastoral letters was addressed to Pastor Johann Hess who wrote to Luther in 1527 on behalf of other clergy in Silesia (Germany) to seek advice about whether Christians may flee from the bubonic plague to save their lives.[596] This bubonic plague or

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[593] When Luther was delegating the responsibility of teaching children the Catechism (the basics of Christian knowledge which shapes people's faith and morality) to parents, he sarcastically upheld women as bishopesses - Luther, "Ten Sermons on the Catechism," p. 137.

[594] Ingemar Oberg, "Mission and Salvation History in Luther and the Confessional Writings," in LWF, *Lutheran Contributions in the Missio Dei*, Geneva: LWF 1984, p. 36.

[595] Luther, *Luther: Letters of Spiritual Counsel*. See also Luther, "Whether one may flee from a deadly plague," p. 114-138.

[596] Martin Luther, "Advice in Time of Epidemic and Famine: To John Hess, November, 1527," in Theodore Tappert (ed), *Luther: Letters of Spiritual Counsel*, London: SCM Press, 1955, p. 230. See also Luther, "Whether one may flee from a deadly plague," p. 116. See also Georg Scriba, *Martin Luther Reaction to the Ravishing Plague and its Meaning for the HIV/AIDS Pandemic in Southern Africa*, Pietermaritzburg:

Black Death broke out in Europe between the fourteenth and seventeenth centuries and claimed millions of lives.[597] When the plague hit Wittenberg on August 2, 1527, university academics – including Luther were instructed to move to Jena, a nearby town. However, although the university was temporarily moved to Jena and later to Schlieben, Luther together with a few others remained behind to care for the afflicted.[598] I will now look at Luther's instructions on how Christians and the state were to address the consequences of the plague. I will also examine the relevance of these instructions in regard to the HIV and AIDS pandemic in our contemporary context.

6.4.1 Caring for sick persons

Luther made it clear that Christians had both freedom and responsibility in dealing with the plague in that some individuals who did not have someone to care for were free to move, while others were to stay and offer care to sick individuals.[599] Pastors were the first category of people who were instructed to stay behind (rather than fleeing) and to offer spiritual care to the sick and the dying. The second category was the public officers such as mayors and judges, due to their leadership responsibility within the community. Luther insisted that secular authority was instituted and commanded by God to care for the entire community. He supported his argument with Paul's letter to the Romans: "…for there is no authority except from God, and those authorities that exist have been instituted by God…for the authorities are God's servant" (Rom. 13:1-6).[600]

Lutheran Theological Institute, 2005, p. 2. Georg Scriba, "The 16th Century Plague and the Present AIDS Pandemic: A Comparison of Martin Luther's Reaction to the Plague and the HIV/AIDS Pandemic in Southern Africa Today," in *Journal for Southern Africa,* 126, 2, (November 2006), p. 67.

[597] Scriba, *Martin Luther Reaction to the Ravishing Plague,* p. 2.

[598] Luther, "Whether one may flee from a deadly plague, p. 115. See also James M. Kittelson, *Luther the Reformer: The Story of the Man and His Career*, Minneapolis: Augsburg Publishing House, 1986, p. 210. Martin Brecht, *Martin Luther: Shaping and Defining Reformation 1521-1532*, Minneapolis: Fortress Press, 1990, p. 207.

[599] Luther, "Whether one may flee from a deadly plague," p. 117, 121. See also Luther, "Advice in Time of Epidemic and Famine," p. 231, 232.

[600] Luther, "Whether one may flee from a deadly plague," p. 121. See also, Luther, "Advice in Time of Epidemic and famine," p. 231, 232.

For Luther, whatever profession a person had, they were serving God.[601] In other words, not only those who were ordained for the ministry of the word and sacraments were serving God. Therefore, the third category of people who were required to provide care to those related or close to them comprised neighbours, servants, and their masters/mistresses as well as parents and their children. Emphasizing the family's and community's responsibility in caring for their sick members, Luther said that the leader of each house ought to be his [sic] own "hospital director."[602] Similarly, he argued: "We must give hospital care and be nurses for one another in any extremity or risk the loss of salvation and the grace of God."[603] To be a "hospital director" could be interpreted to mean that each head of the household should lead by example rather than giving directives to other members of the family to care for a sick person. Since most of the homes are led by men, they were thus assumed to play a central role in providing physical, emotional and spiritual care since healing entails all these components. In other words, care-giving has to address the wholeness of a person.

In Luther's time pastors, mayors, judges and masters were all males since careers in the public were exclusively reserved for men. But neighbours, parents and children (who were also instructed by Luther to care for the sick) were obviously both males and females. The point here is that, in crisis times, Luther did not confine the task of care-giving to only a few people but extended it to all Christians regardless of their gender, profession and status. I want to believe that the care-giving which was given during the crisis time was not divided according to gender lines, but that both men and women provided the same care such as counselling, feeding, bathing and dressing the sick.[604] The

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[601] Luther, "Whether one may flee from a deadly plague," p. 121. See also Paul Althaus, *The Ethics of Martin Luther,* Philadelphia: Fortress Press, 1972, p. 40.

[602] Carl Reuss, "Health Service," in John Bodensieck (ed), *The Encyclopedia of the Lutheran Church*, Vol. 11, Philadelphia: Fortress Press, 1965, p. 991. See also Luther, "Advice in Time of Epidemic and Famine," p. 237.

[603] Brecht, *Martin Luther: Shaping and Defining the Reformation,* p. 208.

[604] The following describes the event that unfolded during the World Trade Center terrorist attack in September 11, 2001 in New York City (USA). Both men and women worked as a team in helping the victims of this attack over several days at St. Paul Chapel - the Episcopal Church situated close to the World Trade Center which became a relief center. One of the associates in the ministry at St. Paul's (Reverend Lyndon Harris) testifies that: "More than 5 000 people used their special gifts to transform St. Paul's into a place of rest and refuge. Musicians, clergy, podiatrists, lawyers, soccer moms, and folks of every imaginable type poured coffee, swept floors, took out the trash, and served more than half a million

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same principle ought to be applied in the context of HIV and AIDS in that Christians – men and women, professionals and non-professionals – are urged to provide care to the sick.

On practical level, Luther and his wife Kathy took many individuals who were stricken by the plague into their own house and provided care to them until their recovery, to the extent that "their home remained under quarantine even after the plague left the city."[605] The example set by Luther and his wife needs to be emulated by Christian couples and congregants in general. In other words, Luther demonstrated the theological concept of love to the neighbour when he said that a Christian is called to be "a Christ to his neighbour" as noted earlier. A neighbour in this context is anyone who needs help or assistance, and to be Christ to a neighbour is to meet their needs in a way Christ meets our daily needs through his unconditional love. Luther's concern about the plague revealed God's saving work to the afflicted through the love of Christ.

As shown in the previous chapter, most of the diocese's HIV and AIDS programmes are carried out by the PHEP team who are the diocese and circuit coordinators and zonal educators. Only the diocese and circuit coordinators are full time employees,[606] whereas the others are working on a voluntary basis because they have various professions in the government or within the church and others again are self employed. They range from being social workers to farm-workers, veterinarians, teachers, evangelists, parish workers and health workers. Family members of the sick persons are also directly involved in implementing the programmes as they offer care to their sick and dying relatives. Moreover, parish staff and elders are responsible in providing spiritual care as PLWHA respondents mentioned in the previous chapter. The fact that the PHEP members have

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meals." Source: National Geographic Magazine, "After the towers fell, a tiny 18th century Episcopal church became a relief center. Clergy counselled, cooks dished out meals, and medical workers treated stiff muscles and burned feet," <http://mgm.nationalgeographic.com/ngm/0209/st_pauls/online_extra.html > Accessed: 19/11/2010, p.1.

[605] Kittelson, *Luther the Reformer,* p. 210. See also Scriba, "The 16th Century Plague," p. 71.

[606] The diocese coordinator is the overall organizer of the Public Health Education Programme (PHEP) who works hand in hand with the circuit coordinators. The diocese coordinator is paid by the diocese, whereas those of the circuits are paid by their respective circuits. The diocese has five circuits, and each circuit has one coordinator. In this study only four circuits were studied due to the geographical location of Karatu circuit, as explained in chapter one.

undergone extensive training related to HIV and AIDS leads to the assumption that they are uniquely responsible for dealing with matters around the pandemic, which places a very heavy burden on them. The massive impact of HIV and AIDS requires the involvement of the entire community – men and women as demonstrated by Luther and the community of St. Paul Chapel in New York to address the challenges posed by the pandemic. By so doing, many more needy or sick persons can be reached more often. This will also lessen the burden on the team members, and women who are the prime care-givers for the sick as shown in the previous chapter. I argue that church members have not been made sufficiently aware and mobilized to participate fully in HIV and AIDS programmes. Instead the work is left to a small group of people, which is contrary to Luther's exhortation. The next section will examine the care for orphans.

6.4.2 Protection or care for orphans

Luther extended the provision of care to orphans too. This implies that in the absence of parents, orphans may be neglected by society as well as being subjected to exploitation, violence and abuse. In this view, Luther urged guardians or close friends to care for them or for other appropriate arrangements to be put in place.[607] As discussed in chapter five, there are a growing number of orphans as a result of the HIV and AIDS pandemic and the majority are still cared for within their extended family, usually by their grandparents who have minimal income. At the same time, a few are supported by their parishes in various ways such as by covering school related expenses, clothes, and food. However, a large number of orphans are in need of care and support since most families that have absorbed them are overstretched, and thus issue of orphans remains as a major challenge to the diocese today. The importance of individuals keeping away from sources of infection and of the afflicted taking their medication will be the topic of my next discussion.

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[607] Luther, "Whether one may flee from a deadly plague," p. 122. See also Luther, "Advice in Time of Epidemic and Famine," p. 233.

6.4.3 Precautions to avoid infection and the taking of the medication

Luther's advice on how persons could avoid infection and the precautions which the infected persons could take, including medication, was effective. This indicates that Luther was concerned with saving life, which is also the underlying motive of the church in initiating the HIV and AIDS programmes. Luther put an emphasis on the use of medication to counter the beliefs of significant sectors of the population that the bubonic plague was God's punishment for their sins; and that they were therefore not in need of medicine.[608] In the previous chapter we saw how the church's HIV and AIDS programmes also have a biased theology of sin, by not allowing condom use for those who are unmarried, yet allowing it for those who are married and infected, citing condoms as a medical device.

Luther's emphasis on the need for sick persons to take their medicine can also be linked to the need for individuals to undergo HIV testing to know their HIV status, as well as with the need for persons on ARVs to adhere to their medical regime. How to prepare someone for death was also the advice of Luther to the people of his time, to which I now turn.

6.4.4 Prepare people for death

While Luther emphasised a theology of life by urging those who are sick to take medication and prevent diseases from spreading, he was at the same time very aware that death is a reality. Hence, for Luther, the need for physical care was of equal importance to the care of the soul, and he therefore gave advice on how an individual needs to prepare their soul before death. He thus highlighted five procedures which he thought were essential.[609] First, an individual was obliged to attend church to listen to the word of God. Luther described worship as showing "complete trust in God."[610] In his view, a person who did not go to church had separated themselves from God, and was condemned as a pagan. For Luther, a Christian ought to be an active church member,

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[608] Luther, "Whether one may flee from a deadly plague," p. 131.

[609] Luther, "Whether one may flee from a deadly plague," p. 134, 135. See also Brecht, *Martin Luther: Shaping and Defining the Reformation,* p. 208.

[610] Eric W. Gritsch, *Fortress Introduction to Lutheranism,* Minneapolis: Fortress Press, 1994, p. 117.

regularly attending church. Coupled with that was to the need to attend confession. This aspect is linked to the former in that if a person was not a regular church-goer, he/she missed the opportunity to confess their sins to God and to each other. This resonates with Luther's statement: "When I urge you to go to confession, I am simply urging you to be a Christian."[611] Christian life is intended to be a life of confession since we are sinners before God and we sometimes wrong our neighbours. In the time of Luther, confession was thoroughly part and parcel of the Christian tradition. As Eric Gritsch says, "Going to confession was like going to a trusted therapist today."[612] Since the church considered the plague as God's punishment for the sins of humanity,[613] which were associated with immoral behaviour, excessive eating and drinking, this may also have motivated Luther's insistence on attending confession for the sick person.

The third step a sick person was to undergo was to take Holy Communion once a week. As in the case of confession, partaking of the Eucharist was and is a way in which a Christian receives the forgiveness of sins.[614] Emphasizing the importance of the sacrament, Luther says:

> But those who feel their weakness, who are anxious to be rid of it and desire help, should regard and use the sacrament as a precious antidote against the poison in their systems…in the sacrament you receive from Christ's lips the forgiveness of sins, which contains and conveys God's grace and Spirit with all his gifts, protection, defence, and power against death and the devil and all evils.[615]

Luther regarded sin as a poison in the human body; therefore the partaking of the Holy Communion serves as remedy. It also acts as a protection against evil forces. The absolution through which an individual's sins are forgiven brings healing and peace.

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[611] Gritsch, *Fortress Introduction to Lutheranism*, p. 122.
[612] Gritsch, *Fortress Introduction to Lutheranism*, p. 122.
[613] Scriba, *Martin Luther's Reaction to the Ravishing Plague,* p. 3.
[614] Paul Althaus, *The Theology of Martin Luther*, Philadelphia: Fortress Press, 1966, p. 378. See also *Martin Luther, Luther's Large Catechism*, Minneapolis: Augsburg Publishing House, 1935, p. 179. Martin Luther, "The Sacrament of the Altar," in Theodore Tappert (ed), *The Book of Concord*, Philadelphia: Fortress Press, 1959, p. 454.
[615] Luther, "The Sacrament of the Altar," p. 454.

Even if the sick person has no hope of recovering, the assurance that they are in good relationship with God plays a significant role in their Christian life.

Reconciling a person with their neighbour was another advice given by Luther in terms of preparing for death. A neighbour here can be a spouse, a relative or another person outside the family. The ministry of reconciliation is centred in the proclamation of forgiveness; thus, through forgiveness comes reconciliation.[616] This ministry also is vital for people living with HIV and AIDS because they tend to blame themselves, to feel angry towards the ones who infected them, and to feel responsible for their partners whom they have infected. They are also angry with other people and even towards God.[617] Reconciliation will help them to come to terms with one another and with themselves. Although Luther insisted on this with regard to the sick, it is essential for Christians at all times since no one knows the hour of their death. Reconciliation restores relationships and brings healing for both parties. The final advice given by Luther was the importance of timely pastoral care when a sick person requests it. In this view, Luther is urging that a minister has to be called timeously while a person is still in a conscious state. In other words, it is meaningless and improper for a pastor to minister to someone who is no longer conscious. This advice falls particularly on the shoulders of the individuals who are nursing their sick relatives to ensure that everything is arranged in time.

Luther's pastoral instructions with regard to preparing someone for death are good Christian practice for spiritual growth, but they appear judgmental to a person who is already sick who may feel guilty for having failed to fulfil these requirements. Nurnberger states that Luther was indeed critical of those who were not church goers while they were healthy, and who desire to utilize the services of the church only during their illness.[618]

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[616] Richard H. Bliese and Craig van Gelder, *The Evangelizing Church: A Lutheran Contribution*, p. 82.
[617] Nicolson, *God in AIDS?* p. 171. See also Chauke, "Theological Challenges and Ecclesiological Response to Women Experiencing HIV/AIDS," p. 142.
[618] Nurnberger, *Martin Luther's message for us today,* p. 294.

To return to our present context, the diocese's HIV and AIDS team does not deal with just the physical needs of the sick persons, but also with their emotional and spiritual needs. The team provides counselling and comfort. Should a person request pastoral care during the visits of the HIV and AIDS team, they will communicate with their parish pastor so that this can be arranged. People suffering from any illness who are unable to go to church are visited and ministered to in their homes. This includes PLWHA, the elderly and others irrespective of their genders. In other words, no sick person is forced to go to church, to confess or to be reconciled to another person as Luther instructed. Experience shows that people suffering from any disease are eager to review their lives and prepare for death. Some confess and others reconciled willingly with their neighbours or relatives.

During my parish ministry, I came across various cases of individuals who felt that they needed to confess in the course of their illness. I will illustrate this with examples of two young people. One of them sent his mother to call me as I was the pastor of the parish at that time. During the visit, the sick person shared that he was involved in drug abuse for a long time and wanted to confess this. The drugs had affected him to such an extent that he was unable to walk without being supported by someone. Before I left, I offered him absolution and a prayer as is expected by Christians when their pastors visit them in times of joy or sorrow. The second example is of another young man in his thirties who was unmarried. He was away from home for a long time and when he fell sick he returned. His church elder informed me that he required pastoral care. When I visited him, he revealed his unfaithful life which he thought was the cause of his illness and to which he wanted to confess. The person had all the symptoms of HIV but he did not mention it. Again I offered absolution and a prayer as indicated above. Both young men subsequently died some time after I had left the parish.

For someone who wants to be reconciled with another person, the procedure seems generally to follow the above examples. For instance, in 2008, a church member who was ailing sent a message to his pastor to come and help him become reconciled with his brother after their relationship had been bad for many years. The two brothers were

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reconciled and each had the opportunity to forgive the other. Not long after, the sick brother died. Unlike Luther, the church does not demand that its congregants confess or be reconciled with others, but people choose to do so voluntarily. In this regard, Luther's instructions in preparing someone for death are not compatible to our context. The need and desire for confession and reconciliation comes from individuals and not from the uppermost church authorities.

6.5 Critical reflections on Luther's theology from a gendered perspective

Luther was neither a medical practitioner nor a social worker, but his theological and practical input in addressing the issue that was at hand – the bubonic plague - provides an example of how the church could engage fully in combating the HIV and AIDS pandemic in our time. To begin with, Luther opposed the views of individual Christians who believed that they need not to flee from the scourge because death was God's punishment of humanity for its sins; and who were consequently waiting for their punishment. However, while encouraging some to escape the pandemic ravaged-areas, others were instructed by Luther to remain behind. Those who were to stay were pastors, mayors, doctors and individuals who had a sick family member or neighbour needing their care.[619] Furthermore, Luther laid down practical instructions that could help to alleviate the situation, for example, taking precautions to avoid infection and medication to deal with it once infected. Finally, while Luther underlined what he thought would be appropriate in dealing with the plague, he was flexible in that people were given freedom to use their common sense and to do whatever they thought would be appropriate for the situation they were in. Therefore at the end of his letter, he wrote: "That would be my advice. Follow it, who so wishes. If anyone knows better, let him go ahead. I am no man's master."[620] Luther did not want to be a dictator but rather a facilitator.

The diocese HIV and AIDS team that is responsible for guiding and helping church members to protect themselves from HIV infection, and for dealing with the aftermath of the pandemic follows Luther's leadership model because it does not force individuals to

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[619] Luther, "Whether one may flee from a deadly plague," p. 120, 121.
[620] Luther, "Whether one may flee from a deadly plague," p. 137.

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do or implement whatever is offered to them. For instance, individuals are encouraged to go for voluntary counselling and testing. The statistics for persons who visited the two church related health centres from 2004 to 2007 are clearly lower than the total population residing within the localities as shown in the previous chapter. If individuals were forced to go for HIV tests, the statistics might have been higher and many more people would have known about their HIV status.

The team also encourages PLWHA and their family members to run small income generating projects to create a sustainable livelihood. Those who accept the idea are able to produce or purchase food, as opposed to those who reject it or who are unable to implement it. These two examples show that the team is acting as a facilitator since the team members give advice with regard to actions they think may be helpful to PLWHA, but are free to follow or to refuse the advice. In the following section, Luther's theological strengths and weaknesses will be highlighted.

6.5.1 Strengths of Luther's theology

Nurnberger argues that much of Luther's theology lacks historical situation and shows inconsistency.[621] However, from the examination above, it is clear that Luther was able to use the contextual situation of his time to develop appropriate theological responses. Luther reminded Christians to be caring towards the sick, the task that Christ assigned to the church as its mission to God's people. Word and actions were both of importance in Luther's theological thought. He built his argument on the commandment of love which demands us to love God and our neighbours. Nurnberger insists that to love one's neighbour is equal to loving God, and what we fail to do for our neighbour we fail to do for God.[622] Christians' engagement in serving the needy (the sick) is a service to God. It is part of the good works that Christ himself initiated during his ministry through word and deeds. Christians are commissioned to extend this service to their neighbours because of God's love for humanity. As stated earlier, Luther was not a person who simply instructed others to do the work; rather he subjected himself to serve the afflicted.

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[621] Klaus Nurnberger, "Luther as reformer of the church," in J.W. Hofmeyr (ed), *Martin Luther,* UNISA: Miscellanea Congregalia, 1983, p. 72.
[622] Nurnberger, *Martin Luther's message for us today*, p. 293.

The PHEP team has set a good example in helping persons living with and affected by the pandemic in various dimensions as reflected in the HIV and AIDS programmes. Of all their activities, the commitment of team members to visit the homes of the sick persons and to provide them with care while preparing family members to assume this responsibility of caring, most notably demonstrates true love to the neighbour who is in need. However, the main burden of nursing the sick falls on the family members. Although a Christian family comprises of both male and female, in practice, it is women and girls who are the prime caregivers for sick persons of both genders because the traditional division of labour specifies distinct roles to each gender, as argued in the previous chapter. Since the law to love one's neighbour is given to all Christians, it is vital that both male and female become conscious of the need to participate fully in caring for their sick relatives. To continue maintaining traditional gender roles is to deny their Christian faith and Christ who offers love to humanity without discrimination

6.5.2 Weaknesses of Luther's theology

There are two weak points which can be identified in Luther's theology of care in relation to the bubonic plague. The first is Luther's usage of rude or abusive language in particular towards people who are already in a difficult situation. The second is his denial of women to the priesthood.

In terms of his harsh language, one example which can be cited is related to individuals who have stopped going to church but who expect the church services at their time of illness. Luther said:

> A person who wants to live like a heathen or a dog and does not publicly repent should not expect us to administer the sacrament to him or have us count him a Christian. Let him die as he has lived because we shall not throw pearls before swine nor give to dogs what is holy. Sad to say, there are many churlish, hardened ruffians who do not care for their souls when they live or when they die. They simply lie down and die like unthinking hulks.[623]

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[623] Luther, "Whether one may flee from a deadly plague," p. 134.

Generally, people living with HIV and AIDS are considered to be responsible for their situation. Although words such as those of Luther above may not be openly spoken, the prejudice against people living with HIV and AIDS is still evident among church leaders as they acknowledged themselves during the HIV and AIDS evaluation workshop held at the Mwangaza Teachers' Resource Centre in Arusha in 2003. Although these leaders fall outside the perimeters of this study, their views may well be representative of the attitude of other church leaders in the Lutheran Church in Tanzania. The leaders who were pastors, evangelists, parish workers and leaders of women's groups from local parishes pointed out that they began to visit PLWHA and their families only after attending an HIV and AIDS seminar organized by the Mwangaza Centre which reminded them of their responsibility to reach out to persons living with and affected by HIV and AIDS.[624] This suggests that home visits, which are part of their pastoral ministry, had until then excluded PLWHA possibly because of the assumption that they were themselves responsible for their condition. It is then clear that HIV and AIDS education for church leaders is a vehicle to refute the concept that PLWHA are being punished by God for their promiscuous behaviour. The importance of educating church leaders on issues related to HIV and AIDS is also emphasized by Ezra Chitando who says: "One strategy to help the church break through this theological rigidity is to train and retrain its ministers in the area of HIV."[625] Regular HIV and AIDS seminars for church leaders are crucial in mitigating the negative perceptions associated with HIV and AIDS. If clergy are well informed about the pandemic, they have the potential to encourage their congregants in turn change their attitude towards PLWHA and become a welcoming and a caring community for HIV positive people.

Luther had also used harsh language regarding the infected persons who intentionally spread the pandemic to others as discussed above. He therefore expressed: "My advice is that if any such persons are discovered, the judge should take them by the ear and turn

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[624] Kari Hartwig, "Confronting Religion, AIDS and Gender in Tanzania: Church Leaders at the Crossroads," in *Journal of Constructive Theology*, 12, 2, (2006), p. 33.
[625] Ezra Chitando, *Living with Hope, African Churches and HIV/AIDS*, Vol. 1, Geneva: WCC Publications, 2007, p. 24.

them over to master jack, the hangman, as outright and deliberate murderers."[626] Luther had no mercy to those who did not have mercy to others. Their intention was to kill and they too were to be killed. "An eye for an eye and a tooth for a tooth" (Mat.5:38). In this view, Luther was too extreme and he was going contrary to the gospel of love and forgiveness.

Secondly, a great weakness of Luther's theology was his refusal to allow women access to the priesthood. Based on Scripture, Luther acknowledged that through baptism every Christian is commissioned to participate in God's mission by their witness and service (1 Pet. 2:9). However, Luther singled out the ministry of preaching the Word of God and the administering of the sacraments as tasks that could only be performed by males and thus denied women the opportunity to utilize their gifts. Luther's stance is based on two arguments. First, he argued that although every Christian has an equal share in the priesthood of all believers not everyone can be a teacher, a preacher or a counsellor.[627] This is to say that an individual has certain skills but not others, and cannot therefore perform all the possible tasks. For this reason, there are professions which are, according to Luther, reserved or meant to be carried out by a specific gender only in spite of all humankind being one in Christ. In this case, pastoral ministry is regarded as a male profession, and women are excluded and assumed to be incapable because of their gender or their low status in society. This low status appears to be linked – both in African and Western thought – with women's biological make up. In other words, the ordained ministry is regarded as holy whereas women are considered by some to be unclean due to their biological nature[628] and would therefore defile this holy ministry were they to take part in its administration.

Another argument made by Luther was that an individual cannot assume the office of a pastor without the call from a parish or congregation. Luther stated: "In a Christian community one should not "draw attention to himself" by assuming this office on his

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[626] Luther, "Whether one may flee from a deadly plague," p. 132, 133. See also Luther, *"Advice in Time of Epidemic and Famine,"* p. 243.
[627] George, *Theology of the Reformers,* p. 97.
[628] Letty Russell, *Church in the Round: Feminist Interpretation of the Church*, Kentucky: John Knox Press, p. 1993, p. 142.

own. Rather he should "let himself be called and chosen to preach and to teach in the place of and by the command of the others."[629] Luther made clear that it is the community of believers (the parish) which calls a person to serve in this position. For both Luther and the Catholics from whom he had split, this person must be a male. Even the language used by Luther specifies the pastor as male. If Luther was at all conscious of the possibility of including both genders in this ministry, he would have been the appropriate person to introduce this inclusiveness in the church as part of the Reformation that he initiated.

In relation to my study, I argue that it is crucial that more women become involved in pastoral ministry. Women's struggle to fight for their rights are relevant to Nunberger's argument that Christians have to confront issues that the Reformers and their descendants "have never been aware of or that they have neglected."[630] The exclusion of women in the leadership of the church is one of those issues that have been ignored, as is evident in my study of the ELCT Northern Diocese which still has only 20 (7%) women clergy in the diocese. Although the struggle has begun, in that women are being ordained in the diocese, the pace is very slow and sometimes deliberate barriers are put in place, which continue to make it difficult for women to enter the ministry on a par with men. Feminists regard the exclusion of women in the church as contrary to the mission of God which focuses on bringing life, healing and freedom.[631]

Women form the majority of the church membership, and of those attending worship,[632] and are also those disproportionately affected by HIV in Tanzania (see appendix 12). Cuthbert Omari observes that in Tanzania there are men who oppose the involvement of women in leadership merely because they regard women's place to be in the home,

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[629] George, *Theology of the Reformers*, p. 97.
[630] Nurnberger, *Martin Luther's message for us today,* p. 148.
[631] Sarojini Nadar, "On Being Church: African Women's Voices and Visions," in Isabel Phiri and Sarojini Nadar (eds), *On Being Church: African Women's Voices and Visions*, Geneva: WCC Publications, 2005, p. 19.
[632] Oduyoye, *Daughters of Anowa*, p. 186. See also Janet Crawford and Michel Kinnamon, *In God's Image: Reflections on Identity, Human Wholeness and the Authority of Scripture,* Geneva: WCC Publications, 1983, p. 28. Mary Tororeiy, "Voices from the Periphery: Being Church as Women in Kenya," in Isabel Phiri and Sarojini Nadar (eds), *On Being Church: African Women's Voices and Visions*, Geneva: WCC Publications, 2005, p. 165.

giving service but not leading.[633] Given that the HIV and AIDS programmes are not sufficiently gendered, this suggests that perhaps an increase in the number of women in leadership positions could have an effect on the gender consciousness of the programmes, as women will be able to bring their issues to the table for discussion. The fact that Luther excluded women from the pastoral ministry was an indication that he intended them to carry forth the traditional roles assigned to them by society.

6.6 Conclusion

This chapter began by describing the theological beliefs underpinning the HIV and AIDS programmes of the ELCT Northern Diocese. It further highlighted Luther's theological thinking around the bubonic plague, and considered that his response was an example of his missionary activity. His response to the bubonic plague of his time was therefore used to assess the responses of the church today with regard to the HIV and AIDS programmes. Caring for the sick and orphans, taking precautions to avoid infection and utilizing medication as well as preparing people for death were areas that were highlighted in relation to HIV and AIDS programmes of the diocese. While there were a number of strengths in Luther's theological arguments, there were also at least two weaknesses which were identified and assessed as inappropriate for the church's theological response to HIV and AIDS: Luther's judgmental language toward the sick and his denial of women to access the priesthood. The next chapter will conclude the study by proposing theologies that encourage relevant HIV and AIDS programmes from a gender perspective.

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[633] Cuthbert Omari, "Women's Ordination: A Viewpoint from Tanzania," in Musimbi Kanyoro (ed), *In Search of a Round Table: Gender, Theology & Church Leadership*, Geneva: WCC Publications, 1997, p. 153.

CHAPTER SEVEN

TOWARDS GENDER-SENSITIVE THEOLOGICAL RESPONSES TO HIV AND AIDS

7.1 Concluding summary

The aim of the study was to analyze whether the prevailing HIV and AIDS programmes/policy of the diocese have adequately responded to the gender-sensitive and theological challenges that reinforce the spread of HIV among its members. The study was therefore guided by the following objectives: a) to describe and analyze the HIV and AIDS programmes/policy of the ELCT Northern Diocese; b) to investigate whether the HIV and AIDS programmes/policy are gender sensitive; c) to describe the theological beliefs underpinning the HIV and AIDS programmes and to ascertain to what extent these encourage gender awareness, and d) to develop theologies that encourage relevant HIV and AIDS programmes that consider both women and men. As I approach the end of the study, I will present a summary of each chapter and a discussion on the objectives of the thesis.

The first chapter, which formed the introduction of the study, examined the background and motivation of the study. I argued that the effects of the HIV and AIDS pandemic are so enormous that each member of society is affected in one way or another. Given that the church plays such a big role in the lives of people in Tanzania, the need for the church to engage fully in responding to the consequences of the pandemic is all the more urgent. Additionally, the pandemic puts a heavy burden on women in caring for sick relatives and orphans due to the fact that care-giving is a gender specific role assigned to women. Having stated the research problem, the objectives and the hypothesis of the study, I highlighted the link between gender and HIV by referring to the works of the Circle of Concerned African Women Theologians and other scholars in sub-Saharan Africa. It was evident that women are severely affected by the pandemic due to their subordinate position in society which is reinforced by social, cultural, economic and religious factors. Unfortunately, the church has not been sufficiently prophetic in addressing those gender issues which continue to threaten women's lives.

Chapter two underlined the three theoretical frameworks that were selected to analyze the data. The first frame of reference was the gendered conceptual framework for assessing HIV and AIDS interventions as proposed by Rao Gupta. The conceptual framework was employed to evaluate the government and diocese's HIV and AIDS programmes/policy to see whether they are gender sensitive. Feminist cultural hermeneutics was the second framework, which was used to analyze the varied cultural elements that promote the transmission of HIV as was highlighted in the subsequent chapters. The third framework was Luther's theology of suffering, healing and gender issues. Luther's theology of suffering revealed that God is in the midst of people who are suffering from various circumstances including people living with HIV and AIDS. Meanwhile, Luther's theology of healing was based on medication, caring for the sick, visiting the sick, prayer and the laying on of hands upon the sick. This theology of healing was referred to in the analysis of the preventive and medical care measures, as well as the spiritual and emotional care offered by the diocese's HIV and AIDS programmes. Luther's theology with regard to gender was articulated and compared with the position of women in the contemporary church in Tanzania. Generally, Luther denied women a position in the ministry of the church, hence confining them to the domestic sphere as mothers and wives, which remains the perception of the church today, though with little improvement.

In chapter three, I described the research methodology used to collect data. Individual in-depth interviews with guided questions were the methods employed in this study. Forty nine participants from the grassroots to the top levels of the church consented to be interviewed. Apart from oral interviews, participant observation, case studies, and the diocese's minutes, reports, and annual meetings were consulted as well as various secondary sources.

The fourth chapter sketched the context of HIV and AIDS in Tanzania. The modes of HIV transmission were underlined as were the socio-economic and cultural determinants of the pandemic. These include poverty, migrant labour, female genital mutilation, early marriage and polygamy. Finally, the government response to the pandemic was explored. HIV and AIDS education, care for people living with and affected by HIV and AIDS and

human rights and gender issues were core to this response. However, it was found that these programmes had not adequately addressed the gendered nature of the pandemic.

Chapter five described the diocese's HIV and AIDS programmes which was the first objective of the study. The second objective was to offer a gender analysis of the HIV and AIDS programmes/policy using both a gendered conceptual framework of assessing HIV and AIDS programmes as proposed by Rao Gupta and African feminist cultural hermeneutics as pioneered by Kanyoro. The programmes numbered eight in total and they fell under three areas: programmes on HIV and AIDS education awareness, programmes that deal with medical care and programmes that deal with social and spiritual care. The study found that most of these programmes were not gender sensitive.

The sixth chapter described the theological beliefs underpinning the HIV and AIDS programmes/policy based on Lutheran doctrine and Luther's theologies. These theologies were: the theology of good works; the theological concept of love for one's neighbour; a theology of the freedom of a Christian and the theology of the priesthood of all believers. This was followed by an analysis of the ways in which the Lutheran church perceives its mission and how this has been demonstrated through the HIV and AIDS programmes of the ELCT Northern Diocese. The chapter concluded that while these theologies are helpful in that they encourage people to show care and compassion in the face of the pandemic and its effects, they are limited in that they remain at that level. They do not address the underlying systems that fuel the spread of HIV such as gender injustice, as demonstrated in chapters 4 and 5.

Therefore, finally, in this seventh chapter, I will propose some theologies that take into consideration the issue of gender justice: theologies which can provide a further basis for the work of the HIV and AIDS programmes. Given that HIV and AIDS is a life-threatening pandemic, and it is mainly transmitted through sexual activity, I propose two additional theologies to the theologies of good works, love for one's neighbour, freedom of a Christian and priesthood of all believers (all focus on care) as outlined in chapter 6. These theologies are a theology of life and a theology of the body and sexuality.

7.1.1 A theology of life

As has been demonstrated throughout this study, the HIV and AIDS pandemic has claimed many lives. A large number are not yet sick but are living with the virus, and many thousands have been left orphaned, and have lost their partners or children due to the pandemic. This reality is an indication that HIV and AIDS denies people' life in its fullness, as it daily intensifies pain, suffering, despair and fear in individuals and society at large. Acknowledging the negative impact of HIV and AIDS on humanity, Ruele contends that the pandemic is killing people in greater numbers than war; hence it represents a total denial of life.[634] In contrast to the life-denying systems which perpetuate HIV, abundant life is a gift from God, and as Jesus declares in the Gospel of John: "I came that they may have life, and have it abundantly" (Jn. 10:10b). A theology of life that I propose here is based on this core principle. Furthermore, a feature of this theology of life is that it is holistic in its approach as opposed to being narrowly moralistic.

In my research I found that there were at least two areas which promote life-denying rather than life-giving theologies. The first was the issue of condom use. While the programmes and policies of the diocese provide condoms to discordant couples, they do not do the same for women and men in general. Their lack of provision of condoms to the different categories of people who need them, is based on issues of morality.[635] Moralistic theologies are life-denying in that they focus exclusively on individual action, as opposed to structures that are oppressive. For example, three of the respondents said: "The church does not promote condom use because it will encourage promiscuity" (PM-10 on 26/02/2007, PM-5 on 22/02/2007 & CD-4 on 23/01/2007). Meanwhile the diocese's HIV and AIDS draft policy states:

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[634] Ruele, "Facing the Challenge of HIV/AIDS in Southern Africa," p. 79.
[635] Denis, "Sexuality and AIDS in South Africa," p. 74. See also Phiri, "HIV/AIDS: An African Theological Response in Mission," p. 428.

> ELCT Northern Diocese will not promote the use of condoms for single people…The diocese will discuss the use of condom during pre-marital and marriage counselling, particularly for family planning and the prevention of HIV among the discordant couples.[636]

The perception of people that condom use will promote sexually "immoral" behaviour has also been documented by various scholars and bodies.[637]

It is clear that in holding on to these moralistic theologies the church is not practicing a theology of life. It is not taking into consideration that there are wider systemic issues to consider than just promiscuity. It does not consider that gender dynamics prevent women from negotiating safer sex, particularly when culture, as pointed out in chapter 4, is constructed in such a way that it maintains gender hierarchy to the benefit of men. The plight of women in this patriarchal system is also expressed by Chitando, who observes that churches have not adequately supported women's enjoyment of life in abundance. On the contrary, the church continues to uphold men at the expense of women.[638] To promote life, the church therefore has the task to discourage and condemn social structures that reinforce the vulnerability of women to HIV infection. This transformative action can take place only if the church (diocese) revisits its HIV and AIDS programmes and policy, by not just confining its role to moral concerns but also by tackling real gender and social concerns. I therefore argue that the prophetic role of the church is to ensure that the theology of life is restored by all means, in order for people to have life in its fullness as offered by Christ. As noted in chapter five, the diocese's HIV and AIDS programmes lack gender awareness, a situation which is demonstrated by its refusal to provide preventive measures to all who need it, especially in patriarchal contexts where women's decision-making ability regarding sex is hampered by culture and religion. Therefore in the context of HIV and AIDS, a theology of life is more appropriate than a moralistic theology which is very narrow in its definition of "morals" and "ethics."

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[636] KKKT-DK, "Sera ya Dayosisi ya Kupambana na Virusi vya UKIMWI na UKIMWI," p. 11, 12.

[637] A WCC Study Document, *Facing AIDS*, p. 61. See also Garland, *AIDS is Real and it's in our Church*, p. 211. Phiri, "HIV/AIDS: An African Theological Response," p. 428.

[638] Ezra Chitando, *Acting in Hope: African Churches and HIV/AIDS Vol. 2*, Geneva: WCC Publications, 2007, p. 6.

The second area in which moralistic theology finds its way into the practice of the church is through stigma and discrimination. For example, even some of the participants who were part of the policy making group were of the opinion that HIV and AIDS is a punishment from God. At least two of the participants openly declared this by saying that:

> HIV and AIDS is the whip of God [against] people because they have turned away from him. Young people as well as adults are involved in sexual immorality, the behaviour which has caused the pandemic to spread from one person to the other (PM-5 on 22/02/2007).

> The perception of many people is that HIV and AIDS is a punishment from God because of immoral behaviour which is so rampant in our time. It is God's way of warning us (PM-9 on 18/02/2007).

By holding onto judgemental theologies such as the above, these policy makers encourage life-denying theologies rather than life-promoting ones. A theology of life is one that is non-judgmental. This is in line with Lutheran theology, which asserts that we are all saved by grace, and not by merit.[639] To deny people the grace of God, particularly in the context of HIV and AIDS is to deny them life.

A theology of the body and sexuality, which I turn to now, is another theology that encourages relevant HIV and AIDS programmes that consider both men and women.

7.1.2 A theology of the body and sexuality

Following Tinyiko Maluleke and other scholars, I argued that a theology of sexuality is crucial in our time because "one of the consequences of human sexual expression today is HIV/AIDS." [640] Sexuality has been regarded as a private matter or personal affair so that

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[639] Tappert (ed), *The Book of Concord*, p. 30.
[640] Tinyiko Maluleke, "Sexuality," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS Sensitive Guidelines and Liturgy,* Geneva: WCC Publications, 2003, p. 134. See also Gideon Byamugisha, "Sexuality," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS Sensitive Guidelines and Liturgy*, Geneva: WCC Publications, 2003, p. 138. Nicolson, *AIDS: A Christian Response*, p. 20. Mwaura, "Violation of Human Rights," p. 136. Denis, "Sexuality and AIDS in South Africa," p. 75.

open discussion on this subject is more or less a taboo in many communities in Africa.[641] The reality of this reluctance is clarified by Agrippa Khathide who says, "We often find that when we talk about sex in public, we are faced with comments like, 'Don't talk about sex, we are Christians' or 'Don't talk about sex, we are Africans.'"[642] Such phrases indicate that sexuality is considered as dirty, shameful or evil and as something that ought not to be discussed openly, despite the fact that it is central to daily life. In other words, sexuality can only be practiced but not spoken about. Khathide further argues that unless the conspiracy of silence around HIV and AIDS – and its means of transmission (sexual intercourse) - is broken, all efforts to address the pandemic will fail.

In traditional Chagga society, the initiation ceremony which took place after puberty was the most important stage of life for both boys and girls as it prepared them to assume family and community responsibilities as mature people. Despite the negative aspect of female genital mutilation which formed part of the rites and encouraged women's submission to their husbands as noted in the study, there were also positive aspects such as the fact that intensive sex education was offered to both genders during these ceremonies.[643] This education presented a breakthrough of knowledge on sexual matters, and taught that individuals must remember and live up to the sacredness of sexuality in their marriages. Thus, fines or penalties were inflicted to discourage any form of sexual misconduct. This resonates with the argument of Peasgood et al. who have pointed out that:

> [As regard sexuality] there existed a relationship between behaviour and a sense of belonging to one's community. Society was organised in such a way that violation of rules was minimal and it was impossible for individuals to break what was the socially accepted code of conduct.[644]

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[641] Bernadette Mbuy Beya, "Human Sexuality, Marriage, and Prostitution" in Mercy Oduyoye and Musimbi Kanyoro (eds), *The Will to Arise: Women, Tradition, and the Church in Africa,* Pietermaritzburg: Cluster Publications, 2006, p. 155. See also Weinreich and Christoph Benn, *AIDS- Meeting the Challenge,* p. 47. Paul J. Isaak, "Culture and Bible in Times of Aids" in *God breaks the Silence: Preaching in Times of Aids*, Wuppertal: United Evangelical Mission, (2005), p. 46. Ayanga, "Religio-Cultural Challenges in Women's Fight against HIV/AIDS in Africa," p. 41.

[642] Agrippa Khathide, "Teaching and Talking about Our Sexuality: A Means of Combating HIV/AIDS," in Musa Dube (ed), *HIV/AIDS and Curriculum: Methods of Integrating HIV/AIDS in* Theological *Programmes,* Geneva: WCC Publications, 2003, p. 1.

[643] Lema, *The Foundation of the Lutheran Church in Kilimanjaro*, p. 243, 245.

[644] Peasgood, et al. (eds), *Gender and Primary Schooling in Tanzania*, p. 155.

Gradually, this positive cultural practice ceased and no alternative has filled the gap, despite the onset of the HIV and AIDS pandemic which spreads as a consequence of human sexual activity. It is this silence that leads to the spreading of the pandemic in African communities.

The above argument was noted by one of the respondents who maintained that the lack of sex education for all age groups within the church was one of the contributing factors in the transmission of HIV. This respondent therefore insisted that the church has to teach the truth about sexuality to help individuals make informed healthy decisions concerning their lives and those of others (PM-6 on 27/2/2007). This argument reveals the weakness of the church in promoting family life education for the well-being of its members. The respondent's emphasis on sex education echoes Denis who contends that:

> To change sexual behaviour, one has to talk about it…Sexual behaviour - and leading on from that, relations between men and women - will only change for the better when sexual questions are discussed freely in an atmosphere of respect for each other and with an understanding of the social culture.[645]

Breaking the silence around sexual matters through open dialogue which involves both men and women can eliminate risky behaviour by individuals or couples, thus creating an atmosphere of love and mutual trust. This is also in line with Isaak who states that in the face of the HIV and AIDS pandemic, the church and the community are challenged to talk openly about human sexuality since cultural and religious taboos which prevent people from speaking explicitly about the subject are lethal in the present context.[646]

Why should the church talk openly about sexuality? It has to be spoken about openly because human beings are created as sexual beings, as stated by UNAIDS:

> God created us as unique persons and differentiated beings. God delights in our differences, and invites us to do the same. God created us as sexual beings in all our differences. This is to be

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[645] Denis, "Sexuality and AIDS in South Africa," p. 75. See also Paul Isaak, "A Biblical and Ethical Response to HIV/AIDS," p. 63.
[646] Isaak, "A Biblical and Ethical Response to HIV/AIDS," p. 63.

celebrated; enjoyed and treated responsibly…God's gift to us is the capacity to enjoy one another as sexual beings, and it is we who have squandered that gift. God created us for one another and for God, and wants us to celebrate the gift of sexuality through which God's Creation unfolds.[647]

Similarly Jean Garland maintains that:

In the church's witness to the world regarding HIV/AIDS, we must make clear that God calls us to celebrate sex as his gift. Christians should not be against sex, only against its misuse. In God's wonderful plan of marriage, sexual satisfaction and pleasure are not only allowed but encouraged.[648]

The above quotations demonstrate clearly that sexuality is a gift from God to humanity, and that God invites human beings to celebrate and enjoy it in a responsible manner. One of the factors which my study highlighted was the way in which gender inequality within sexual relationships leads to the spread of the virus.

Given that sexuality is sacred,[649] it ought not "to be abused or trivialized either by denial or by promiscuity because it bears the stamp of the divine nature."[650] The unfaithfulness of men which has caused many married women to contract the virus is one way in which sexuality has been abused. For human beings to be able to maintain the sacredness of their sexuality, the church has then the task to teach its adherents about the goodness of sexuality and about the responsibility we have toward each other in order to prevent actions that expose others to pain, suffering and ultimately to HIV and AIDS. Studies have revealed that the majority of married women who are HIV positive have been infected by their unfaithful partners as discussed in chapter five. Similarly, the findings of my research showed that there are more women than men who have HIV tests, and therefore more women who are on treatment as opposed to men. This does not mean that

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[647] UNAIDS, "HIV and AIDS related Stigma: A Framework for Theological Reflection," Windhoek: Namibia, 2005, p. 3. See also Weinreich and Benn, *AIDS – Meeting the Challenge*, p. 47. Mwaura, "Violation of Human Rights," p. 136.

[648] Garland, *AIDS is Real and it's in our Church,* p. 294.

[649] Stephen C. Barton, *Life Together: Family, Sexuality and Community in the New Testament and Today,* Edinburgh: T & T Clark, 2001, p. 76.

[650] Barton, *Life Together,* p. 76.

men are not infected and in need of medication. Rather as I mentioned earlier, the cultural concepts of masculinity prevent men from seeking earlier HIV testing and treatment. For example, during my field work within one of the parishes, no male respondent living with HIV and AIDS came forward as a respondent due to the fact that many men in this circuit[651] (as elsewhere) are ashamed of their HIV positive status and hence are reluctant to seek treatment (OP-4 on 08/02/2010). This was also subsequently confirmed to me by the parish pastor (30/02/2007). Furthermore, the refusal of the sick young man to go to the hospital for treatment until he was persuaded to do so by his neighbour, as mentioned in chapter six, was obviously influenced by the concept of masculinity that does not allow men to show that they are weak even in situations that risk their lives.

The view of Lisa Isherwood and Elizabeth Stuart with regard to the theology of the body is that the woman is a site of oppression.[652] Sexuality is a site of subjugation because culturally and theologically women are regarded as objects to satisfy males' sexual desire and not vice versa. They therefore contend that: "What we are able to say is that our culture holds patriarchal views of the body and our church reflects all these negative traits. Christianity and patriarchy are highly compatible bed-fellows."[653] The view of patriarchal societies concerning the woman's body is similar to that of the Church Fathers[654] - a view point that has not been refuted and it thus serves as a "norm" of society. This is evident because neither society at large, nor the church has taken initiatives to deal with these gender issues that, in today's context, make women vulnerable to HIV infection. In other words, women are still expected to be obedient to their husbands despite the risks involved.

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[651] My interviews covered four parishes - one parish from each of the four studied circuits of the diocese within Kilimanjaro region.

[652] Lisa Isherwood and Elizabeth Stuart, *Introducing Body Theology*, Ohio: The Pilgrim Press, 1998, p. 15. See also Mwaura, "Violation of Human Rights," p. 129.

[653] Isherwood and Stuart, Introducing Body Theology, p. 19. See also M. M. Pieterse & C. Landman, "Feminist responses to the historical and current influence of belief on sexual relationships," *Studia Historiae Ecclesiasticae*, p. 238.

[654] Geneviele Lloyd, "Augustine and Aquinas," in Ann Loades (ed), *Feminist Theology: a reader*, London: SPCK, 1990, p. 91. See also Clifford, *Introducing Feminist Theology*, p. 30. Elizabeth A. Clark, *Women in the Early Church: Message of the Fathers of the Church*, Wilmington: Michael Glazier, 1983, p. 65. For instance, Augustine was convinced that it was God's will that women ought to be subject to their husbands in marriage.

The vulnerability of women to HIV infection affirms that men have failed to honour others as sexual beings and to honour life. The extra marital relationships which are common among some Chagga men as discussed earlier is one of the actions that have predisposed women to HIV infection. A theology of sexuality therefore demands the empowerment of women in order for them to have control over their bodies. This notion is strongly emphasized by various scholars. Chitando argues that:

Married women need to be empowered to protect themselves. They are made in God's image. They should not surrender their lives in order to be deemed good wives…Marriage needs to be re-conceptualized as partnership.[655]

Similarly, Nicolson asserts that:

Churches need to locate sex within a relationship of love, not legalism. Because it is important in AIDS ministry that women be empowered to have some control within relationships, we need to move our people away from a mentality that sees sex as a man's right and a woman's duty, something which men have a right to demand of women. [656]

The above arguments spell out why women have to be empowered to protect themselves from HIV infection. First, women like men are created in the image of God so they have the right to live by rejecting any action or behaviour that threatens their lives. Second, in marriage, a woman is not regarded as an equal partner but as someone who must fulfil her duty to satisfy her husband's sexual desire when demanded to do so. Thus, the emphasis on a theology of partnership as opposed to a theology of headship, will guide individuals to a mutual relationship that does not hurt the other partner but promotes life in its fullness.

Furthermore, a theology of sexuality demands the church to break the silence surrounding sexual matters and to challenge socio-cultural practices and actions that "destroy

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[655] Ezra Chitando, "Women," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy*, Geneva: WCC Publications, 2003, p. 188. See also Chitando, *Acting in Hope*, p. 10.
[656] Nicolson, *AIDS: A Christian Response*, p. 21. See also Nicolson, *God in AIDS*? p. 234.

women's well-being and self-esteem."[657] Given that human beings are created as sexual beings, issues with regard to sexuality ought to be spoken about openly. Maluleke argues that there are biblical passages that deal openly with sexuality which is an indication that the church has to do likewise as a strategy in this era of HIV and AIDS.[658] Open dialogue on sexuality will help Christians to recognize the beauty thereof and act responsibly within their relationships.[659]

In conclusion, among the various theologies which can promote life in the context of the gendered pandemic of HIV and AIDS, this study has proposed two major theologies not only for the ELCT Northern Diocese to consider in their HIV and AIDS programmes/policy, but for the church at large. Firstly, a theology of life demands the church to relinquish moralistic theologies. These moralistic theologies include in particular, the refusal of the use of preventive measures, especially in a context in which women are culturally subordinate to men in sexual relationships, making it difficult for them to protect themselves from HIV infection, and the judgmental attitude towards people living with HIV and AIDS which reinforces stigma and discrimination. Secondly, a theology of the body and sexuality urges the church to empower women to have a say over their sexuality while condemning the current male domination in sexual matters. This theology also urges the church to speak openly about sexuality, which is a central aspect of human life, in order to guide people to responsible sexual behaviour that can in turn save their lives and those of others. As long as the church does not consider the gendered nature of HIV and AIDS, its efforts to overcome the pandemic will bear little fruit.

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[657] Mwaura, "Violation of Human Rights through Stigma and Discrimination," p. 138.
[658] Maluleke, "Sexuality," p. 135.
[659] Ezra Chitando, "Sexuality," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS* Sensitive *Sermon Guidelines and Liturgy*, Geneva: WCC Publications, 2003, p. 137. See also Gideon Byamugisha, "Sexuality," in Musa Dube (ed), *Africa Praying: A Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy*, Geneva: WCC Publications, 2003, p. 139.

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APPENDICES

Appendix 1 : Interview questions to policy makers

A) General information

Gender: ……………………...

Age: ………………………….

Education: Primary/Secondary: ……………………………..

Position held/not held in the church: ………………………..

Name of the institution/circuit………………………………

B) The Participants' understanding of issues around HIV and AIDS

1. What are the contributing factors to the spread of HIV in our community?

2. Which methods do you think are the best to combat the spread of HIV?

3. What strategies can be applied for relevant and effective HIV prevention and
   care that consider both women and men?

4. What strategies can be applied to overcome HIV and AIDS related stigma among men
   and women?

C) Theological perspective

1. What is the diocese's theological interpretation of HIV and AIDS?

2. How should the diocese treat people living with HIV and AIDS?

3. Why should they be treated the way you answered it?

4. How do you see God in relation to this incurable disease?

Appendix 2: Interview Questions to PHEP coordinators

A) General information

Gender: ……………………...

Age: ………………………….

Education: Primary/Secondary: ……………………………..

Position held/not held in the church: ………………………..

Name of the institution/circuit: …………………………….

B) The Participants' understanding of issues around HIV and AIDS

1. What are the contributing factors to the spread of HIV in our community?

2. Which methods do you think are the best to combat the spread of HIV?

3. What strategies can be applied for relevant and effective HIV prevention and
   care that consider both women and men?

4. What strategies can be applied to overcome HIV and AIDS related stigma among men
   and women?

C) HIV and AIDS Programmes

1. What do the diocese's HIV and AIDS programmes entail?

2. To what category of people is HIV and AIDS education is offered in the parish?

3. What are the components of the teaching to each category?

4. a) How is the HIV and AIDS education carried out within the local parishes?
   b) How often is it offered? c) When?

5. Who are responsible in carrying out the HIV and AIDS education/programmes?

6. What kind of training do they have?

7. What is used to measure the effectiveness of the programmes?

8. What part of the HIV and AIDS education addresses gender issues?

9. What challenges do you face in implementing the HIV and AIDS programmes?

10. Are your programmes linked with the work of:

    a) government?

    b) non-governmental organisations?

c) other agencies?

11. If yes, a) how are they linked ?

       b) what are these?

   12. If not, why not?

D) Gender awareness

1. What is your understanding regarding the role that men /women play in the spread of HIV? Give reasons for your answer.

2. Between men and women who do you think is more vulnerable to HIV infection? Give reasons for your answer.

3. How can the diocese curb the gender factors that contribute to the transmission of HIV?

4. What should the church do with regard to rape cases?

5. How do you think the church ought to respond to the issues of infidelity in marriage?

6. Who are the caregivers for people living with HIV and AIDS?

7. Why only those people you have mentioned?

E) Stigma awareness

1. Why is HIV and AIDS surrounded by stigma?

2. How is HIV and AIDS related stigma reinforced within our community?

3. What is the effect of HIV and AIDS related stigma in our community?

4. Are you aware of any HIV + woman or man who is stigmatised? If yes, what is his/her experience?

Appendix 3: Interview questions to PHEP zonal educators

A) General information

Gender: ……………………...

Age: ………………………….

Education: Primary/Secondary: ……………………………..

Position held/not held in the church: ………………………..

Name of the circuit: ………………………………………...

B) The Participants' understanding of issues around HIV and AIDS

1. What are the contributing factors to the spread of HIV in our community?

2. Which methods do you think are the best to combat the spread of HIV?

3. What strategies can be applied for relevant and effective HIV prevention and
    care that consider both women and men?

4. What strategies can be applied to overcome HIV and AIDS related stigma among men
    and women?

C) HIV and AIDS Programmes

1. What do the diocese's HIV and AIDS programmes entail?

2. To what category of people is HIV and AIDS education is offered in the parish?

3. What are the components of the teaching to each category?

4. a) How is the HIV and AIDS education carried out within the local parishes?
    b) How often is it offered? c) When?

5. Who are responsible in carrying out the HIV and AIDS education/programmes?

6. What kind of training do they have?

7. What is used to measure the effectiveness of the programmes?

8. What part of the HIV and AIDS education addresses gender issues?

9. What challenges do you face in implementing the HIV and AIDS programmes?

10. Are your programmes linked with the work of:

    a) government?

    b) non-governmental organisations?

c) other agencies?

11. If yes, a) how are they linked ?

b) what are these?

12. If not, why not?

D) Gender awareness

1. What is your understanding regarding the role that men /women play in the spread of HIV? Give reasons for your answer.

2. Between men and women who do you think is more vulnerable to HIV infection? Give reasons for your answer.

3. How can the diocese curb the gender factors that contribute to the transmission of HIV?

4. What should the church do with regard to rape cases?

5. How do you think the church ought to respond to the issues of infidelity in marriage?

6. Who are the caregivers for people living with HIV and AIDS?

7. Why only those people you have mentioned?

E) Stigma awareness

1. Why is HIV and AIDS surrounded by stigma?

2. How is HIV and AIDS related stigma reinforced within our community?

3. What is the effect of HIV and AIDS related stigma in our community?

4. Are you aware of any HIV + woman or man who is stigmatised? If yes, what is his/her experience?

Appendix 4: Interview questions to members of the congregation

A) General information

Gender: …………………….....

Age: ………………………….

Education: Primary/Secondary: ……………………………..

Position held/not held in the church: ………………………..

Name of the parish: …………………………………….....

B) The Participants' understanding of issues around HIV and AIDS

1. What are the contributing factors to the spread of HIV in our community?

2. Which methods do you think are the best to combat the spread of HIV?

3. What strategies can be applied for relevant and effective HIV prevention and
   care that consider both women and men?

4. What strategies can be applied to overcome HIV and AIDS related stigma among men
   and women?

C) HIV and AIDS Programmes

1. What do the diocese's HIV and AIDS programmes entail?

2. To what category of people HIV and AIDS education is offered in the parish?

3. What are the components of the teaching to each category?

4. a) How are HIV and AIDS education is carried out in the local
      parishes?

   b) How often is it offered? c) When?

5. Who are responsible in carrying out HIV and AIDS education?

6. Is the education helpful or not helpful in preventing the spread of HIV?

   a) If yes, how have it been helpful?

   b) If not, what are the reasons?

D) Gender awareness

1. What is your understanding regarding the role that men /women play in the

spread of HIV? Give reasons for your answer.

2. Between men and women who do you think is more vulnerable to HIV infection? Give reasons for your answer.

3. How can the diocese curb the gender factors that contribute to the transmission of HIV?

4. What should the church do with regard to rape cases?

5. How do you think the church ought to respond to the issues of infidelity in marriage?

6. Who are the caregivers for people living with HIV and AIDS?

7. Why only those people you have mentioned?

E) Stigma awareness

1. Why is HIV and AIDS surrounded by Stigma?

2. How is HIV and AIDS related stigma reinforced within our community?

3. What is the effect of HIV and AIDS related stigma in our community?

4. Are you aware of any HIV + woman or man who is stigmatised? If yes, what is his/her experience?

Appendix 5: Letter to the diocese requesting for permission to conduct research

UNIVERSITY OF
KWAZULU-NATAL

Rt Rev Martin Shao
ELCT Northern Diocese
PO Box 195
Moshi
Tanzania
4th December 2006

Dear Rt Rev Martin Shao

RE: Request for Permission for Rev Rose Materu to conduct research

This is certify that Rev Rose Materu is my PhD s Degree student in the programme of Gender and Religion and Ethics, School of Theology at the University of KwaZulu-Natal.

Rev Rose Materu has completed her research proposal. She now has to conduct field research in fulfillment for her degree. The title of her dissertation is **"The Response of the Northern Diocese of the Evangelical Lutheran Church in Tanzania to HIV/AIDS"**

I am therefore writing to request that Rev Rose Materu be given permission to carry out this research in your Diocese. With your permission, we expect her to start her research in January 2007.

Any assistance that you can offer her to achieve her research goals is greatly appreciated

Yours sincerely

Professor Isabel Apawo Phiri
Head: School of Religion and Theology

School of Religion and Theology

Postal Address: Private Bag X01, Scottsville 3209, Pietermaritzburg, South Africa

Telephone. +27 (0)33 260 5540   Facsimile: +27 (0)33 260 5858   Email: thec-sec@ukzn.ac.za   Website: www.hs.ukzn.ac.za/theology

Founding Campuses: Edgewood   Howard College   Medical School   Pietermaritzburg   Westville

Appendix 6: Letter of approval to conduct research

Evangelical Lutheran
Church in Tanzania
NORTHERN DIOCESE

PF/Materu, Rose (Rev)/192

12th December, 2006

Kanisa la Kiinjili la
Kilutheri Tanzania
DAYOSISI YA KASKAZINI
P. O. Box 195, **MOSHI**, Tanzania
Telephone: (027) 2754359/2754360
Fax: (027) 2750144
Cables: LUTHERAN , Moshi
E-mail: elctnd@kanisa.net

Rev. Rose Materu
ELCT Northern Diocese
P.O. Box 195
MOSHI

Dear Rev. Materu,

Re: **PERMISSION TO CONDUCT RESEARCH**
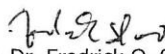
Greetings in the Name of our Lord Jesus Christ.

I am very much pleased to hear from your Prof. I.A. Phiri that you have completed your PhD research proposal. Congratulations!!

With this letter I would like to introduce you to all institutions and areas in our Diocese where you may like to conduct your field Research, and to grant you permission to conduct your Research on "The Response of the ELCT Northern Diocese to HIV/AIDS" within our Diocese.

It is my hope that you will receive good cooperation. I wish you success and fulfillment in your research.

May the joy and Peace of Advent and Noel be with you.

In Christ,

Rev. Dr. Fredrick O. Shoo
ASSISTANT TO THE BISHOP

Copy to: The Rt. Rev. Bishop Martin F. Shao

Prof. Isabel A. Phiri
University of Kwazulu Natal
School of Religion and Theology
Private Bag X01, Scottsville 3209
Pietermaritzburg
SOUTH AFRICA

FOS:eddy

Appendix 7: Letter to the respondents requesting for their participations in the study

Evangelical Lutheran
Church in Tanzania
NORTHERN DIOCESE

Kanisa la Kiinjili la
Kilutheri Tanzania
DAYOSISI YA KASKAZINI
P. O. Box 195, **MOSHI,** Tanzania
Telephone: (027) 2754359/2754360
Fax: (027) 2750144
Cables: LUTHERAN , Moshi
E-mail: elctnd@kanisa.net

PF/Materu, R. (Mch)

9 Januari, 2007

Yah: <u>**UTAFITI WA MCH. ROSE HILDA MATERU**</u>

Ninakusalimu katika Jina la Bwana na Mwokozi wetu Yesu Kristo.

Mch. Rose Materu ameendelea na masomo yake ya Kozi ya Shahada ya Ubingwa (PhD) katika Chuo Kikuu cha Kwazulu – Natal.

Ili kukamilisha masomo yake Mch. Materu anatakiwa kufanya utafiti kuhusu Jitihada za Dayosisi katika kupambana na UKIMWI.
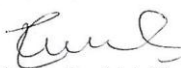
Kwa ajili hiyo atahitaji ushirikiano kutoka kwa wadau kadhaa wa Dayosisi yetu.

Tunaomba wafuatao wampe Mch. Rose ushirikiano katika utafiti huo.

1. Wakuu wa Majimbo Jirnbo la Hai, Siha, Kilimanjaro Kati na Kilimanjaro Mashariki
2. Mjumbe mmoja Halmashauri Kuu Dayosisi toka kila Jimbo
3. Mwenyekiti – Idara ya Wanawake, Mwenyekiti wa Vijana DK
4. Mratibu Elimu ya Afya ya Msingi DK
5. Waratibu wa Majimbo yaliyotajwa juu
6. Wanakamati 4 wa Elimu ya Afya ya Msingi toka kila Jimbo tajwa juu
7. Washarika 5 kutoka usharika mmojawa kila Jimbo wenye Kamati hai ya E/Afya ya Msingi
8. Miniti husika za Halmashauri Kuu za Masjala DK na Majimbo

Ninakutakia heri na fanaka katika Mwaka Mpya 2007.

Wenu katika Utumishi wa Bwana,

Mch. Dr. Fredrick Shoo
MSAIDIZI WA ASKOFU

Nakala: Katibu Mkuu DK

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Appendix 8: Consent form for participation in the research project

Study title: **A Critical Study of the Response of the Northern Diocese of the Evangelical Lutheran Church in Tanzania to HIV and AIDS. A gendered perspective**.

Purpose of the study
Thank you for showing interest in participating in this study. The aim of the research is to learn about the gender challenges that fuel the spread of HIV among the church members of the Northern Diocese, and to suggest how the diocese can draw up a plan of action to address those challenges.

Researcher contacts
Rev. Rose H. Materu, University of KwaZulu-Natal, School of Religion and Theology, Private Bag X01, Scottsville 3201, Pietermaritzburg, South Africa, Tel. 0763986508 (mobile), E-mail: rhilda2001@yahoo.com.
<div align="center">OR</div>
E.L.C.T. Northern Diocese, P.O. Box 195, Moshi, Tanzania, Tel. 0752887222 (mobile).

Project supervisor
Prof. Isabel Apawo Phiri, University of KwaZulu-Natal, Private Bag X01, Scottsville 3201, Pietermaritzburg, South Africa, Tel. 27 33 2606132 (work), 27 72423943 (mobile).

Subject identification
The motivation to carry out this study is based on the challenges of HIV and AIDS I encountered during my service as a minister in the diocese. I encountered a high rate of HIV and AIDS related deaths among young adults, both married and unmarried, and of both sexes. The situation created fear, sadness, anxiety and empathy within the community, as we were all affected. Due to this pandemic, parents lost their children, couples lost their loved ones, and children were orphaned. Those who had grandmothers were cared for by them with minimal resources, as there are no government grants for such cases. Unfortunately, there were also vulnerable children who were infected, thus grandmothers or extended families had the extra burden of caring for and nursing these children. I also noted that the pandemic was putting a heavy burden on women, as they were the caregivers of persons with HIV and AIDS, despite their other duties. This situation led to many unanswered questions in my mind and among many congregants. We tried to get involved in a small way but the question still remains: how best can the church respond to these challenges as the number of people infected and affected by HIV and AIDS continues to increase?

Description of Procedures
If you agree to participate in this study, you will be asked questions designed to get information about the involvement of the diocese in response to HIV and AIDS within our community. The broad categories of the interview include the following a) biographical information such as education, age, gender, position held/not held in the church, name of the circuit/parish; b) church policy and theological perspective on HIV and AIDS (to be answered by the diocese Executive Committee); c) church programmes

and services that deal with HIV and AIDS awareness, prevention and care-giving, stigma and gender sensitivity (to be answered by public health education coordinators and zonal educators, and by the members of the congregation); d) strategies for relevant and effective HIV and AIDS prevention and care that consider both women and men as well as the eradication of stigma related to the pandemic (to be answered by all groups in the study population).

I will interview each individual for about one hour or more. You are free to express your answers as you wish; and as you feel is appropriate. All efforts will be made to ensure that I will be at the meeting place on time, and begin the interviews at the agreed time. In the course of the interview, the study might cause emotional feelings for some who have lost their loved ones, or who are caring for their sick family members, or who are living with HIV, thus free counselling will be available during and after the interviews.

Risk and Benefits

This work is voluntary. Therefore, no payment will be given to any of the participants, because I do not want you to feel that I am buying information from you. Nevertheless, I would like to share information free of charge.

The benefits of the research could be the knowledge obtained from the study, which might bring about positive changes to the individuals or to the community, such as gender construction awareness to prevent the spread of HIV. In addition, your suggestions and comments at the end of the study can also be an input to the development of an effective HIV and AIDS response within the diocese.

Confidentiality

All information gathered from you will be kept confidential, and once the work is complete, it will be destroyed. No names will appear in the academic papers or any report. The use of Abbreviations will be used to assist me in data analysis. Since I am the only person conducting the interviews no information will leak out for any reason. A tape recorder will be used with your consent, though I will also be taking notes during our discussion.

Voluntary Participation

Participation in this study is completely voluntary. You are free to withdraw at any time you feel you would like to do so and for any reason. You will not be penalized for refusing to answer any question, and this will also not harm your relationship with your diocese or me.

Study the document thoroughly, and if you have any question, contact me. After your questions have been answered, and if you decide that you would like to participate, sign your name as indicated below. Kindly bring this document with you to the interview.

Agreement to participate/declaration

I…………………………………………………..,hereby confirm that I understand the contents of the document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the study at any time, should I so desire.

………………………………………..   ……………………
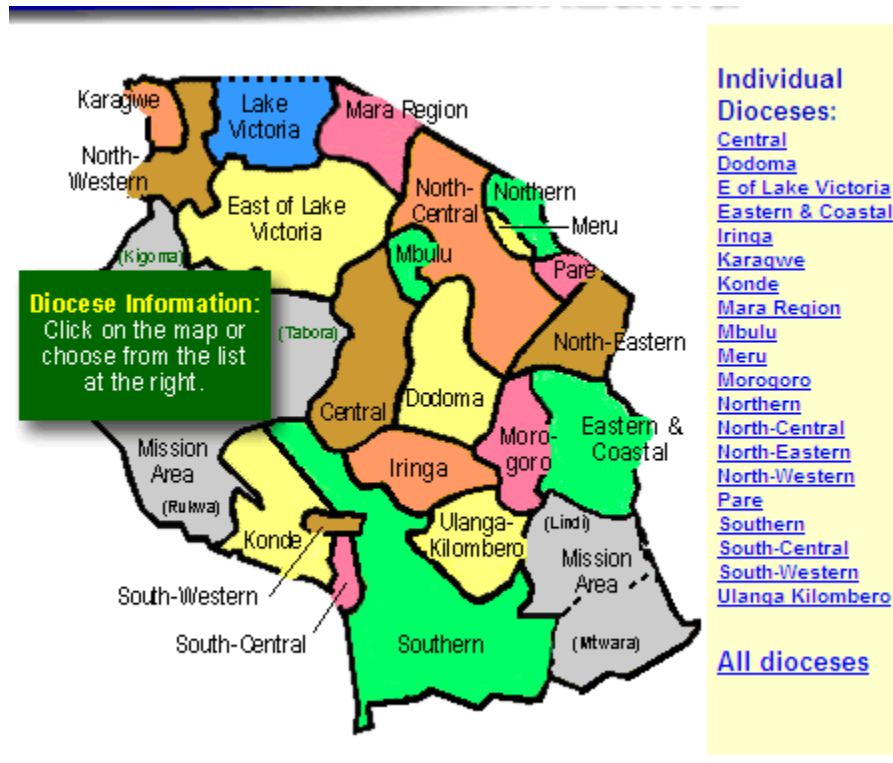   (Signature of participant)   (Date)

Appendix 9: List of participants

Abbreviation	Age	Date of interview
CD-1	60	09/02/2007
CD-2	47	16/02/2007
CD-3	60	05/02/2007
CD-4	50	23/01/1007
CD-5	44	20/02/2007
OP-1	54	19/01/2008
OP-2	66	26/06/2008
OP-3	50	04/06/2007
OP-4	66	28/02/2008
ORP-1	18	19/01/2008
ORP-2	15	26/01/2008
ORP-3	17	15/01/2008
ORP-4	15	09/02/2008
PLWHA-1	40	19/01/2008
PLWHA-2	34	19/01/2008
PLWHA-3	51	26/01/2008
PLWHA-4	36	26/01/2008
PLWHA-5	37	22/01/2007
PLWHA-6	37	04/02/2007
PLWHA-7	40	28/02/2008
PM-1	49	06/03/2007
PM-2	45	23/02/2007
PM-3	65	20/02/2007
PM-4	64	17/02/2007
PM-5	59	22/02/2007
PM-6	67	27/02/2007
PM-7	55	27/02/2007
PM-8	54	07/02/2007
PM-9	53	18/02/2007
PM-10	65	26/02/2007
PM-11	53	23/02/2007
YOUTH-1	27	19/01/2008
YOUTH-2	28	26/01/2008
YOUTH-3	29	22/01/2007
YOUTH-4	19	09/02/2008
ZE-1	50	16/02/2007
ZE-2	58	16/02/2007
ZE-3	56	17/02/2007

ZE-4	55	24/01/2007
ZE-5	44	24/01/2007
ZE-6	68	24/01/2007
ZE-7	56	24/01/2007
ZE-8	59	23/01/2007
ZE-9	46	16/01/2007
ZE-10	50	30/01/2007
ZE-11	64	17/01/2008
ZE-12	34	21/02/2007
ZE-13	43	21/02/2007
ZE-14	57	21/02/2007

Appendix 10: Map showing the location of each of the 20 dioceses of the Evangelical Lutheran Church in Tanzania (ELCT).
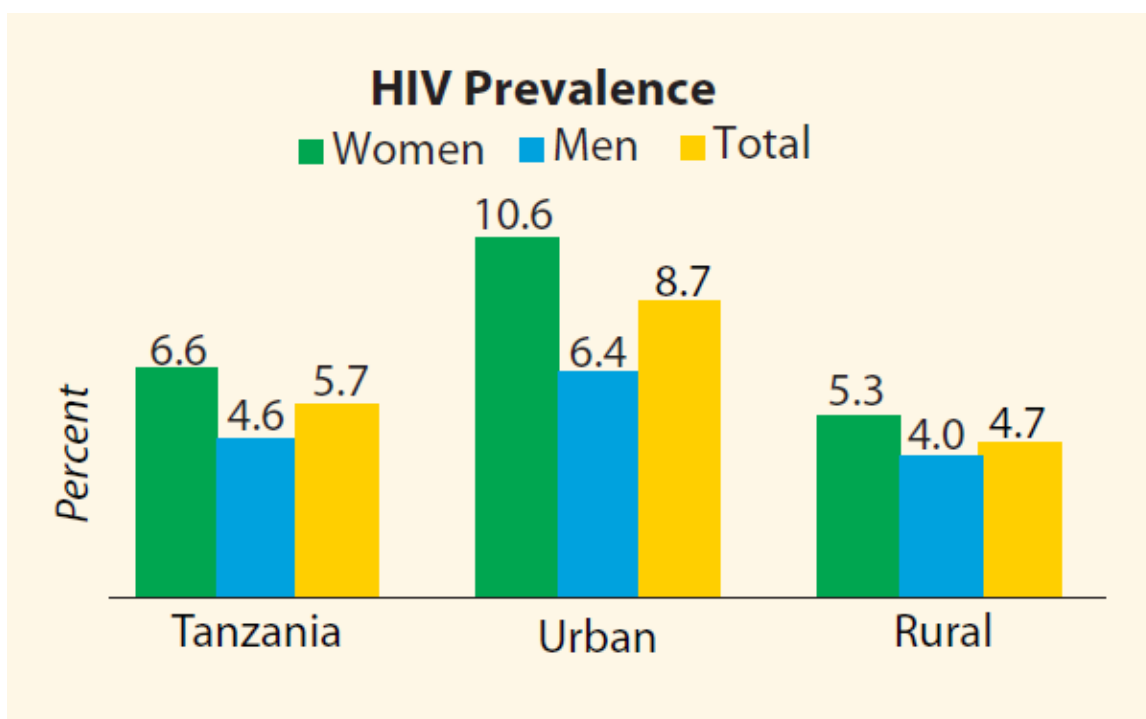

Source: ELCT dioceses, 2010

Appendix 11: Map of the HIV Prevalence by Region in Tanzania 2007-08

Source: National Bureau Statistics (NBS) and the Tanzania Commission for AIDS
(TACAIDS), 2009.

Appendix 12: HIV Prevalence Trend in Tanzania 2007-08

Source: NBS and TACAIDS, 2009

Appendix 13: Diocesan Policy on HIV and AIDS

EVANGELICAL LUTHERAN CHURCH IN TANZANIA- NORTHERN DIOCESE (ELCT-ND)

Diocesan Policy on HIV and AIDS

1. Vision and Mission

This policy is built upon the vision and mission statement of the Evangelical Lutheran Church in Tanzania as shown below.

1.1 Vision Statement

The Evangelical Lutheran Church in Tanzania, Northern Diocese exists to liberate people from the power of the devil, poverty, disease and ignorance in order to have eternal life in Jesus Christ.

1.2 Mission Statement

The mission of the Northern Diocese of the Evangelical Lutheran Church in Tanzania with regard to HIV and AIDS is to enable all people to have life in its fullness. Guided by the word of God, the ELCT-ND shall serve humanity with love: physically, spiritually and socially through teaching them the word of God and providing each of them with education and health. ELCT-ND recognizes the love of God in and among people living with HIV and AIDS. Our mission is to minister to people infected with HIV and AIDS with love and compassion.

2. HIV and AIDS situation in society and within ELCT-ND

2.1 Epidemiological data

Four circuits (districts) out of the five circuits of the ELCT-ND are located in Kilimanjaro region

Indicator	Percentage of population	Kilimanjaro total population (2002)	Number of Christians within ELCT-ND (2005)
Total population	100%	1 381 149	321 565
Prevalence rate (people living with HIV)	7.4%	100 499	23 795
Orphans	12.4%	73 405	19 034
Estimated casualties due AIDS		14 681	3 806

2.2 HIV and AIDS pandemic

AIDS stands for Acquired Immune Deficiency Syndrome. Human Immunodeficiency Virus (HIV) attacks and destroys the body's immune system, which normally protects the body from other infections. The progression of AIDS can be measured by counting the lowering number of CD4+ cells in the blood of an infected person. The CD4+ cells which are white blood cells fight to protect the body against bacteria and other viruses that attack the body. If the immune system is already weakened by HIV and AIDS, opportunistic infections such as Tuberculosis and other bacterial infections will attack the body, hence leading to death.

With regard to the destruction of the immune system, the medical practitioners discern four clinical stages that an HIV positive person goes through from the time of infection to the point where a person infected is said to have AIDS. Those stages are as follows:

Stage	Common Symptoms	Treatment
1. Asymptomatic/silent HIV	No symptoms for AIDS	No specific treatment is needed
2. Symptomatic stage	Minor symptoms: some weight loss, fever, night sweats, skin infections and rashes.	Treatment of opportunistic infections eg. TB
3.Intermediate stage	Much weight loss, Tuberculosis (TB), frequent diarrhea lasting more than one month), fever, skin infections and sores.	TB medication and antiretroviral drugs (ART)
4. Late stage (severe health impairment)	All of the above, but very severe; bedridden more than half the time.	TB medication, ART and palliative care

2.3 Root causes of HIV infection

2.3.1 Modes of transmission

The main mode of HIV transmission is heterosexual activity which accounting for more than 80 percent. The other causes of HIV infection include the mother-to-child transmission and skin piercing activities.

2.4 People who most likely to be exposed to HIV

Similar to other diseases, HIV spreads due to human interaction caused by modern socio-economic activities, which require them to travel. Therefore, individuals who are at high risk of being exposed to HIV are as follows:

2.4.1 Individuals who live along the major roadsides and market places.

2.4.2 Migrant labourers who live far away from their families

2.4.3 Women - They are at higher risk of HIV infection than men for the following reasons:

2.4.3.1 Their biological make up. A woman is the receptive sex partner and infected semen stays in her genital organ for a longer period, giving the virus more opportunity to enter the bloodstream.

2.4.3.2 Young girls indulge in sexual activity at an earlier age than boys of the same age.

2.4.3.3 Girls are forced to early marriages and sometimes are raped; in this case they are subjected to unprotected sex.

2.4.3.4 The majority of women are poor, a situation which forces them to engage in sex work to earn their living.

2.4.3.5 Women are the main caregivers for the sick family members and in course of the care provision may become infected.

2.4.4 People with multiple sexual partners. These are:

2.4.4.1 Commercial sex workers and their clients.

2.4.4.2 Individuals who uphold cultural practices such as wife inheritance and sharing of wives among age mates which is practiced by certain ethnic groups in Tanzania.

2.4.4.3 Teenagers, women and men who engage in pre-marital and extra marital relationships.

2.5 Other factors that reinforce the spread of HIV

2.5.1 Poverty – increases HIV infection in society as it leads people to become involved in trade or business which expose them to HIV infection.

2.5.2 Lack of knowledge about HIV and AIDS, its transmission, its prevention, and treatment and stigma which is also mainly associated with the lack of knowledge. The consequences of lack of knowledge are:

 2.5.2.1 Only few individuals will go for HIV testing and know about their HIV status.

2.5.2.2 A few who are infected will take precautions not to infect others.

2.5.2.3 Few HIV positive persons will get proper medication/treatment

2.5.2.4 Lack of resources needed to prevent the spread of HIV and its treatment.

2.5.2.5 Resorting to sex work as a source of income.

2.6 The impact of HIV and AIDS on society

HIV infection affects individuals mainly at their reproductive age and the members of workforce between the age of 20 and 49. The pandemic is causing the following problems:

2.6.1 It increases the number of orphans and elderly who are not cared for. Orphans who are not cared for migrate to towns and cities where they survive as street children.

2.6.2 The loss of a family breadwinner has a negative economic impact on the surviving family members such as children and the elderly.

2.6.3 Socially, the productive population has a large number of dependants.

2.7 Government's and society's response to HIV and AIDS

2.7.1 The Tanzanian government has established policies for orphans (1994), HIV and AIDS (2001) and home-based care (2005). The government provides free antiretroviral drugs (ARVs) to individuals whose their CD4 cells are below 300. Orphans who are admitted to public secondary schools receive scholarships. The Tanzania Commission of AIDS (TACAIDS) provides funds to the non-governmental organizations (NGOs) and faith-based organizations (FBOs) that are involved in HIV and AIDS projects. ELCT-ND will follow these guidelines (policies) and engage in networking with all the government agencies.

2.7.2 In Kilimanjaro region there are numerous NGOs that are involved in HIV and AIDS activities such as KIWAKKUKI, Compassion, KINSHAI and others. Other churches have also released their policies or they are involved in such projects.

2.7.3 The Evangelical Lutheran Church in Tanzania (ELCT) has released its policy on HIV and AIDS, a policy which is adopted by the ELCT-Northern Diocese through this document.

2.7.4 ELCT Northern Diocese will cooperate with other agencies and NGOs that are dealing with the effects of HIV and AIDS by networking, exchanging data, sharing ideas and creating local communities to address the pandemic in the villages.

3. Our Faith

Our faith is built upon love for God and our neighbours. Therefore, this policy is directed to every person who lives within and outside the ELCT Northern Diocese to have love and compassion for their neighbours, including those who are living with HIV and AIDS. May be God has allowed this pandemic to challenge our mercy and love in order that his name may be glorified (Jn. 9:2; 1Cor. 12:22-26). It is our responsibility to show others our love and compassion because we know that:

3.1 Every Christian can be infected with HIV because of their own sin or someone's sin. A Christian can be infected during charity service. For instance, a health worker can be exposed to HIV infection through needle injuries.

3.2 It is not our task to condemn HIV positive persons on the grounds of their lifestyle, but we are supposed to show them love and compassion (Mat. 5:45; 7:1-2; Jn. 8:7).

3.4 It is our responsibility to be well-informed of the spiritual reasons that may be the cause of any illness. We are supposed to pray without ceasing so that God may bring a solution to the pandemic.

3.4 The root cause of stigmatization of people living with HIV and AIDS is fear. The Bible tells us: "Do not fear!" and "There is no fear in love, but perfect love casts out fear; for fear has to do with punishment, and whoever fears has not reached perfection in love" (1Jn. 1:18). The ELCT-ND is teaching that stigma and discrimination is sin. Thus, individuals who are HIV positive are welcomed to worship with other members.

3.5 ELCT-ND will not allow any of its staff or students within its institutions to be discriminated against or denied because of their HIV positive status.

3.6 ELCT-ND will take all possible precautions to ensure that whoever is working in any of the diocese institutions is not infected with HIV, particularly in the economic projects, medical and educational centres.

3.7 ELCT-ND will not encourage the idea of gathering orphans in the orphanage centres, only in exceptional cases for infants below the age of three will they be cared for in special institutions. It is the responsibility of society to care for orphans with love in their families.

4. The objectives of the HIV and AIDS policy of the ELCT-ND

The main objectives are as follows:

4.1 To eliminate HIV infections.

4.2 To encourage and enable Christians and non-Christians to undergo HIV testing.

4.3 To provide humanitarian social support to people living with HIV and AIDS.

4.4 To provide treatment to PLWHA.

4.5 To ensure the continuum care for PLWHA.

4.6 To provide guidelines for all projects geared to support PLWHA within the diocese.

5. Strategies that will be employed by the HIV and AIDS policy of the ELCT-ND

5.1 To eliminate or prevent the prevalence of new HIV infections

A low prevalence of HIV infection or a low percentage of PLWHA is the measure of the effectiveness of this strategy. This will be implemented as follows:

5.1.1 To teach people so that they know and put in practice the strategies that prevents the spread of HIV.

5.1.2 To eliminate sexually transmitted diseases because their presence increase new HIV infections.

5.1.3 To avoid any other means that causes the transmission of HIV, such as sexual activity. The modes of HIV transmission will be avoided through the following methods:

5.1.3.1 The prevention of mother-to-child transmission through pregnancy.

5.1.3.2 Assurance of safe donated blood and other medical care such as sterilized syringes by the health care providers.

5.1.3.3 To ensure the proper handling of invasive and non-invasive skin penetration during surgical, dental or cosmetic procedures.

5.1.4 Treatment of opportunistic infections

In stages 2-4 HIV positive persons are vulnerable to a series of opportunistic infections due to the weakness of the immune system. For this reason, treatment of opportunistic infections is required.

5.1.5 Palliative care

At the stage of AIDS when a person is in critical condition, the only care that can be offered is to manage the pain by giving them medication to prevent vomiting, breathless or to care for the mouth and skin.

5.1.6 Spiritual care and support

At the stage of AIDS, the sick person and their family need spiritual care and counselling to enable them to understand the stage of their illness in order to access proper medication and nutrition. Family members need to be encouraged to continue caring for their sick person.

5.1.7 Encouragement of the use of antiretroviral drugs

The modern antiretroviral therapy is a combination of more than three drugs to reduce the number of viruses in the blood. These drugs cannot get rid of the virus or cure AIDS but they block steps in the process through which the virus reproduces. Therefore, a person can regain a measure of fairly good health, and get back to their normal life. The HIV positive person is required to take the ARVs twice a day. To stop taking the dose as prescribed, results in the viruses growing back rapidly and thus causes resistance to medication. In case of resistance, there are other antiretroviral drugs called second and third-line drugs, but their roll out is limited. However, HIV positive people are by all means required to check their CD4 status and other important clinical issues. If the individual meets the criteria stage 3 or 4 or if their CD4 counts are less than 300 they are put on ARVs free of charge. The person is required to visit the clinic on a monthly basis for a medical check up and their monthly dose.

5.1.8 To ensure the continuum of care

To ensure the availability of medical care for persons who are HIV positive, the ELCT-ND will improve its medical service in the following areas:

5.1.8.1 Advanced services in hospitals and dispensaries

All diocese hospitals and dispensaries will have HIV and AIDS clinics offering counselling and testing in compliance with the guidelines of the Ministry of Health in Tanzania. ELCT-ND will try to ensure the availability of all forms of medical treatment of HIV and AIDS in its hospitals and dispensaries.

5.1.8.2 Counselling and home based care (HBC)

Due to the growing number of people who are sick because of HIV and AIDS related illnesses, the medical facilities are overstretched in that they cannot absorb all the sick individuals. Thus, the hospital will be responsible for the treatment of opportunistic infections and the provision of ARVs. Palliative care and counselling ought to be offered by health care providers who will visit the sick at their homes and guide the family members to care for their sick relatives. Therefore, the ELCT-ND will introduce HBC in all its parishes which will follow the guidelines of the Ministry of Health. This ministry explains a minimum standard of home based care to include counselling and testing and palliative care. In addition, medication adherence, a referral system, psychological support, nutrition guidance and food support are also part of the package of the HBC. It also mentions the participation of PLWHA, involvement of men, the provision of medical care to children, orphans and vulnerable children, records, the reporting system as well as prevention interventions.

5.1.8.3 Medical and social fund of the ELCT-ND

Though ARVs are free of charge a sick person is supposed to pay for the following services:

5.1.8.3.1 Initial clinical examinations in order to be put into antiretroviral drugs.

5.1.8.3.2 Treatment of opportunistic infections.

5.1.8.3.3 Monthly travelling costs to visit the hospital.

5.1.8.3.4 Palliative care.

ELCT-ND will establish a special account which will support the medical and social costs for individuals who are in abject poverty.

5.1.9 Prevention of the spread of HIV through sexual relationships

The major mode of HIV transmission is heterosexual and homosexual. Other social contacts such as hugging, shaking hands or using the same meal utensils cannot transmit the virus. Transmission can only take place when sexual fluids of an HIV positive person come into contact with a person who is HIV negative. Transmission through nursing a sick person can be avoided by using rubber gloves.

5.1.9.1 The reality of sexual behaviour

Christians need to know that we are not living in a perfect world. A recent study conducted in Mawenzi Hospital revealed that 65% of girls and 35% of boys below 18 years have already engaged in sexual relationships.

5.1.9.2 The ABC strategy

ABC stands for Abstinence, Be faithful and Condoms. Abstinence is the only strategy that will prevent the spread of HIV and thus ensures an individual 100% of their security. God commands his people not to commit adultery and fornication and this is what we will be teaching. We will teach the married partners to be faithful in their marriages. We are told that condoms can only grant a relative protection of 90-97% if they are of good quality and are used consistently and accurately. In the African context where there are some low quality products and low knowledge on the usage of condom, it can only be ensured with minimal success when it is used by one partner who is HIV positive to protect the other partner who is HIV negative. The 2003/2004 study conducted in Tanzania found that 40 couples out of 100 who were using condoms were exposed to HIV infection.

5.1.9.3 Support of A and B strategy

ELCT-ND will fully support Abstinence and Be faithful which are compliance with Christian concept that sexual activity is reserved for married couples only. To have sexual relationships outside marriage is adultery and fornication.

5.1.9.4 HIV prevention through condoms

ELCT-ND will not promote the use of condoms for single people (unmarried people). A research conducted in the USA revealed that teaching about condom use amongst children increases the risk of indulging in sexual activity. However, ELCT-ND will

create an environment which will allow children and young people to ask sensitive questions with regard to sexuality and HIV prevention. ELCT-ND will guide them to find answers for their questions. ELCT-ND will discuss the use of condom during pre-marital and marriage counselling, particularly for family planning and the prevention of HIV among the discordant couples.

5.1.9.5 Behaviour change

Studies affirm high levels of HIV and AIDS awareness among the population in Tanzania but there is little implementation of this knowledge with regard to sexual behaviour. Behaviour change cannot be addressed by one means, for example, through a one day seminar, but is rather a life-long learning process.

ELCT-ND will be involved in HIV prevention for people of all ages and at different occasions, for instance after baptism, at preschool, Sunday school, confirmation classes, youth camps, sermons during on Sunday worship, weddings and funerals.

5.1.10 To promote and facilitate voluntary counselling and testing (VCT).

The effectiveness of this service will be the percentage of people who have received voluntary counselling and testing. A high rate of people accessing this service will prevent further HIV infection and eventually AIDS. If people are aware of their status, they will take precautions not to infect others for those who are HIV positive, or to avoid infection if they are HIV negative. Individuals whose results are negative after HIV testing will benefit from the counselling service which will enhance their knowledge with regard to HIV and AIDS as well as means to avoid HIV infection.

ELCT-ND is providing voluntary counselling and testing in its three hospitals: Marangu, Machame and Karatu. This service is done in accordance to the national and international standards adhering to the following regulations:

5.1.10.1 Confidentiality

The results after HIV testing remain a secret between the health care provider and the client.

5.1.10.2 Pre- and post test counselling

HIV testing is done only after pre-counselling to prepare an individual for the possible results. If the client is willing to be tested after giving his/her well informed consent, the outcome of the test will be discussed in the post-counselling sessions.

5.1.10.3 Voluntary counselling for the public

Generally, every sexually active person is encouraged to know their HIV status to avoid being infected or infecting their sexual partner. However, in the following situations HIV testing is highly recommended

- Pre-marital testing

Before marriage, voluntary HIV testing is encouraged for both partners.

- During pregnancy

During pregnancy voluntary HIV testing is encouraged for the mother in order to prevent mother-to-child transmission**.**

5.1.11 Provision of social and medical support to PLWHA

The targeted groups that need social support are as follows:

5.1.11.1 People living with HIV and AIDS

5.1.11.2 People who have lost their relatives to AIDS related illness such as orphans, widows, elderly and others.

5.1.11.3 The category of people who are at high risk of being infected with HIV because of poverty, including vulnerable children, widows and commercial sex workers.

5.1.12 Strategies to be employed in offering social support

5.1.12.1 To identify the targeted groups and their needs, and to inform the community. ELCT-ND will set up a comprehensive program to list all the needy within their parishes and assess their needs. Data and reports will be presented to the public and the required authorities.

5.1.12.2 To advocate for the basic needs for all in need such as food, shelter, protection, medication, clothes and against discrimination and stigma.

5.1.12.3 To create income generating projects for the infected people to enable them to be self-reliant.

5.1.12.4 To enable the poor to access education. It is education only that can solve the problem of poverty. Special funds to sponsor those from the targeted groups to access basic and secondary education will be established. Those groups are PLWHA, orphans, vulnerable children, widows and others. The effectiveness of this program will be measured by the number of recipients of this service. Social support systems offer spiritual comfort, advocacy, and a process to create self-independence. A good social support system will eliminate poverty, hence reducing the risky sexual behaviour which facilitates the spread of HIV.

5.1.12.5 Medical care for people living with HIV and AIDS.

ELCT-ND will ensure that PLWHA access the medical service. The effectiveness of this service is the percentage of the individuals who will be treated or access the service. This will include counselling, antiretroviral drugs (ARVs), treatment of opportunistic infections and home based care.

6. Guidelines for HIV and AIDS projects within the ELCT-ND

The main focus of these projects is to put into practice what is stated in this HIV and AIDS policy by coordinating with each stakeholder as follows:

6.1 To provide services to PLWHA within the diocese.

6.2 To enable people to have knowledge about HIV and AIDS and to provide counselling for people infected with HIV.

6.3 To coordinate all HIV and AIDS projects which are run by the ELCT –ND and its institutions.

6.4 To prepare a guiding program to address HIV and AIDS and to seek sponsors.

7. The responsibilities of each department and institution

7.1 The task of every Christian- a man or a woman has the following responsibility:

7.1.1 To be tested and to know about their HIV status.

7.1.2 To be well informed about HIV infection and ways to avoid HIV infection.

7.1.3 To take precautions not to infect others if a person is HIV positive or not to be exposed to HIV infection in case they are HIV negative.

7.1.4 To live according to Christian moral ethics of not indulging in pre-marital sex and to be faithful in marriage.

7.2 Duties of the clan, relatives and neighbours

7.2.1 To provide care for the sick relatives at home (HBC).

7.2.2 To support the individuals affected by HIV and AIDS such as orphans, widows and the elderly.

7.2.3 To teach and admonish others about HIV and AIDS and life style, which will protect them from HIV infection.

7.3 The responsibility of society

7.3.1 To give contributions to support diaconal matters/ services

7.3.2 To volunteer in activities related to HIV and AIDS such as home based care, committee activities and others.

7.4 The responsibility of the parish

7.4.1 The parish, which represents the body of Christ, is a place where Christian love becomes real among its members. Therefore, it is the role of the parish to minister to those in need (Acts 6:1-7).

7.4.2 The leadership of the parish and the parish council need to engage fully in this task (1Cor.12).

7.4.3 ELCT-ND will support and encourage individuals who are in crisis whenever possible without discrimination.

7.4.4 Parish staff (pastors, evangelists and parish workers), whose main task is to teach and preach are in a position to guide people to change their behaviour. They will emphasize behaviour change at various occasions such as at the baptism service, pre-school, Sunday school, confirmation classes, sermons on Sundays, weddings and at funerals.

7.4.5 The Public health education committee will be responsible for:

7.4.5.1 Medical care for PLWHA

7.4.5.2 HIV and AIDS education awareness in all its multifaceted arenas.

7.4.5.3 Home based care within the parish.

7.4.6 Duties of the diaconal committee will be:

7.4.6.1 To visit the needy, to counsel and to pray with them

7.4.6.2 To list all the needy and assess their problems.

7.4.6.3 To prepare the annual program geared to support persons infected and affected by HIV and AIDS, and presents its suggestions to the parish council on how to raise funds to meet those needs.

7.4.6.4 To present its activities and data to the leadership of the parish.

Other parish departments will be involved in reaching out to the targeted groups. For instance, the Women Department will be involved in HIV and AIDS issues among women. Similarly, the Youth Department will focus on the youth. The Christian Education Department will mainly be responsible to draw up a curriculum and activities that will sensitize Christians to change their behaviour.

7.5 The tasks of the circuits (districts)

The circuit will be the mediator or implementer of the HIV and AIDS policy between the parish and the diocese. Therefore, its tasks will be:

7.5.1 To disseminate information, knowledge and training within the parishes.

7.5.2 To facilitate capacity building within the parishes, to visit parishes and follow up.

7.5.3 To coordinate parish activities.

7.5.4 To collect information from parishes and evaluate their activities.

Departments at the circuit - namely: Christian Education, Women, Youth, Diaconal, Public Health Education, and Mission and Evangelism - must each have a coordinator and a circuit committee which will be accountable to the circuit executive council. Each department will support parish activities as stated above. The circuit diaconal department which is responsible for AIDS related issues is a representative of the circuit in all diocese meetings with regard to HIV and AIDS. For instance, it will draw up a program, budget and reports according to the guidelines of the diocese on HIV and AIDS.

7.6 Departments and institutions of the ELCT Northern Diocese

The head office of the ELCT-ND and each institution of the diocese will be involved and participate in addressing the HIV and AIDS pandemic by doing the following:

7.6.1 To develop its own departmental or institutional plan showing its contribution in relation to the objectives of the HIV and AIDS policy.

7.6.2 To prepare its annual activities and budget in relation to the objectives, and to secure funds to address them whenever possible.

Each department and institution can therefore contribute to the objectives of the HIV and AIDS policy as illustrated in the table below.

Department/ Institution	Prevention	Medical care	Social support	Capacity building
Medical	Teach about medical issues	Provide medical care for PLWHA	Establish social medical fund	Train medical staff, provision of medical equipment, TOT
PHEP unit	Teach about health care and HIV and AIDS	Home-based care	Counselling and psychological support	Train HBC providers
Diaconal	Teach about	Social funds for	Various forms	Train

	diaconal ministry and caring for PLWHA	diaconal work	of social support to the needy	congregants on diaconal issues
Education	Teach on prevention, behaviour change and Christian ethics	Teach Christians about HBC	Teach about the role of a Christian with regard to his/her neighbour	Training of trainers (TOT)
Women	Teach women how to prevent HIV infection and care for PLWHA	Train women on HBC	Train women on their responsibility to society (*Diakonia)*	Train of women leaders
Youth	Teach young people how to protect themselves from HIV infection and to care for PLWHA	Train young people on HBC	Train young people on their responsibility to society (*Diakonia*)	Train of youth leaders
Project	Teach diocese workers how to protect themselves from HIV infection	Encourage diocese employee to undertake HIV testing	Provide small income generating projects	Training on project management
Tertiary/schools and others	Teach workers and students how to protect themselves from	Teach workers about HBC	Teach workers about their responsibility	Training of trainers (TOT)

	HIV infection		to society	
Kindergarten /primary schools	Teach children how to protect themselves from HIV infection	Train children on HBC	Train children about their responsibility to society *(Diakonia)*	Train teachers and children leaders
Hospitals and dispensaries	VCT and seminars about prevention	The package of HIV and AIDS treatment including HBC	Social medical care	Train medical staff, HBC providers and research

Source: ELCT-ND, Policy on HIV/AIDS (translated from Swahili version)